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**A COMPREHENSIVE PREGNANCY AND FAMILY
MEDICAL CARE LEAVE PROGRAM FOR
THE 21ST CENTURY ARMY**

BY

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USAWC RESEARCH PROJECT

**A Comprehensive Pregnancy and Family Medical Care Leave
Program for the 21st Century Army**

Prepared by

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1999**

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The University of Texas at Austin**

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ABSTRACT

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The Army is currently competing with the civilian community for recruiting and retention of personnel, and monetary incentives alone are not sufficient to do the job. Quality of life issues come to the fore. The advent of the all-volunteer force has resulted in a military with more married than single soldiers, and also increased the Army's need for, and dependence upon, women as soldiers. Young families and women soldiers lead to dealing with issues of pregnancy. Additionally, as our population ages, more soldiers incur responsibilities for elder care.

This paper looks at the issues involved in pregnancy – readiness, unplanned pregnancies, fitness, and breastfeeding – and proposes a comprehensive program to minimize the impact on the Army, the soldier, and the American taxpayer. This proposal includes an education program to: prevent unplanned pregnancies; assist in family planning; promote prenatal maternal and fetal health; and promote postpartum fitness to facilitate faster and easier return to duty status. It also provides an option for extended family care for all medical needs with a family medical care leave of up to one year to assist unit readiness, improve quality of life, and increase soldier commitment to the Army.

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Madigan Army Medical Center, Tacoma, WA

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Army Center for Health Promotion and Preventive Medicine

INTRODUCTION

"To lose the war for talent is to accept a second-rate military in which America's most capable men and women do not choose to serve."¹

Like it or not, the Army is in competition with the civilian community to acquire and retain our 'best and brightest'. Recruiters are struggling, and failing, to make missions. "Like most large companies, the military faces a war for talent -- that is, a battle to recruit and retain officers and enlisted personnel with the intellectual flexibility, technical abilities and communication skills needed today. If it does not fundamentally rethink the way it attracts, develops and retains people, it will lose this war.

"As with many businesses, the problem is retaining talented midlevel people..."² Mid-grade soldiers and officers are choosing to leave the military at a time when they are needed most, and we are offering incentives, higher pay, and revisions to the retirement system to entice them to stay. At the same time, as the Army budget and force structure allowance decrease, it is incumbent upon the Army to gain the most benefit from the personnel it recruits, trains, and needs.

¹ McCormick, David. "The Draft Isn't The Answer." New York Times, February 10, 1999. On-line. Available from <http://ebird.dtic.mil//d/httpd/ebird/Feb1999/e19990210draft.htm>.

² McCormick, David. "The Draft Isn't The Answer." New York Times, February 10, 1999. On-line. Available from <http://ebird.dtic.mil//d/httpd/ebird/Feb1999/e19990210draft.htm>.

In a presentation to his "Perspectives on Public Policy" class at the University of Texas at Austin, ADM (RET) Inman noted that when we established the All-Volunteer Army, the government made promises to the volunteers that they could depend on the continuance of a full twenty-year career. He further stated that the country has been unable to honor that pledge, instituted severe personnel cutbacks, conducted a reduction in force (RIF) at the Major level, and generally is on the edge of not keeping faith with the volunteers.³

Army and military promotion systems are based on the premise that we promote from within and train our personnel in a unique system. It is presumed that "...senior-level military skills aren't transferable. An important part of the armed forces' appeal used to be the tacit understanding that the military would look after its own. But that has now been utterly corroded, severely damaging morale. Meanwhile, junior officers are very attractive to private companies, compounding the problem."⁴

General Dennis J. Reimer, Chief of Staff of the Army, has stated that "Quality of Life – or how soldiers live, and the conditions in which they live and work – is essential to the Army's readiness. Soldiers continuously cite quality of life as a primary factor for joining or remaining in the Army."⁵ Further, the studies indicate that money alone does not entice soldiers to stay. Medical care, housing, education and other quality of life issues are considered key to military job satisfaction and retention.

³ ADM (RET) Bobby Ray Inman, University of Texas at Austin, Austin Texas, 1 March 1999.

⁴ McCormick, David. "The Draft Isn't The Answer." New York Times, February 10, 1999. On-line. Available from <http://ebird.dtic.mil/d/htpd/ebird/Febr1999/e19990210draft.htm>.

⁵ Walker, The Honorable Robert M. and General Dennis J. Reimer. A Statement on the Posture of the United States Army Fiscal Year 1999. Second Session, 105th Congress, February 1998, p. 44.

These quality of life issues are especially important for one group of soldiers, women. There are more women in the Army now than at any time in our history. More importantly, there are more women of childbearing age in the Army than ever before.⁶ Demographically, with the decrease in the male military age population, the advent of the all-volunteer Army, and the upswing in the economy, the Army is more dependent on women soldiers now than ever before. One researcher noted that "...as we move into the 21st century women will be a vital resource for the all-volunteer force."⁷ It is evident that "...the declining pool of eligible male recruits, coupled with the mutual desire of Congress and the Department of Defense to maintain the quality of the recruits attained in recent years, and the political unwillingness to return to the all-male draft, will continue to influence the necessity to recruit women."⁸

Given the current and predicted increase in female personnel, how pregnancy is managed and cared for, crucial life issues for women and families of childbearing age, are significant quality of life considerations. The concern the Army demonstrates when providing medical and administrative care to pregnant soldiers and their families, which includes providing the opportunity to breastfeed their infants, signal to all just how serious the Army is about recruiting and retaining women.

Another factor impinging upon quality of life and career decisions of Army personnel is care for elderly relatives. With the aging and increased longevity of the general population of the United States, more service members will become

⁶ Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998), p. 408.

⁷ Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998), p. 412.

responsible for caring for aged or infirm parents. Although not dependents in the strict, taxable definition, some older parents do require lengthy hospitalization, in-home, or residential care. While primary responsibility for care of older relatives generally falls upon women, there are increasing numbers of male service personnel who have also become the primary caregivers. Elder care could entail a considerable amount of time arranging for such care or providing time for acculturation and accommodation.

A third significant consideration for many service members is a catastrophic illness or injury to a family member. The military currently provides for specific family care needs under the Exceptional Family Member Program (EFMP). For many years now, specific targeted assignments and duty locations is all the Army has done to meet the needs of families in the EFMP.

The Army, as all the military services, is very concerned these days with quality of life issues. Service members read almost daily about attempts to 'fix' the pay gap and retirement systems. They hear how difficult and expensive any solution would be and how the military is attempting to improve quality of life. When these situations - pregnancy and care for the severely injured and elderly - are not adequately managed, morale suffers, productive work diminishes, and soldiers start thinking of civilian life. "The bedrock strength of our military is its ability to attract and keep quality young men and women to their nation's service."⁹ Therefore, the focus of this paper is to review extant options and develop a situationally specific family medical leave policy for the men and

⁸ BeCraft, Carolyn H. "Military Women: Policies and Politics". *The Bureaucrat*. Fall 1991, p. 12.

⁹ *Torchbearer Messenger*. Association of the United States Army, No. 3, January 1999.

women of the 21st Century Army. Any policy or program developed must reflect the fact that our primary competition for the diminishing pool of qualified personnel is the civilian community. General Reimer has further stated that “[o]ur Nation owes its soldiers a quality of life commensurate with that in civilian life...”¹⁰

This new policy must be one that is equitable for the service members AND the Army; a policy that will allow us to keep the trained personnel we want and need; wisely use our fiscal resources; and foster greater commitment of the Army to its soldiers and of soldiers to the Army.

¹⁰ Walker, The Honorable Robert M. and General Dennis J. Reimer, A Statement on the Posture of the United States Army Fiscal Year 1999, Second Session, 105th Congress, February 1998, p. 44.

CURRENT POLICIES/PRACTICES

Finding accommodations for parents in the military has been an ongoing concern. Developing policies and practices for pregnant women is relatively new, and dates back to 1972 when pregnant women were first permitted to remain in the military. Current policies in the military services are relatively consistent across the board (See Appendix A) and generally differ only in time limits for imposition of non-deployability, duty limitations, and weight and fitness requirements upon return to duty.

We have not yet developed an effective and equitable policy to fully utilize women when their capabilities and duty requirements are not in the least restrictive. For example, a soldier working in an office environment and with an uncomplicated pregnancy could work practically to the day of delivery with no limitations whatsoever. Nor is there a policy to accommodate difficult or complicated pregnancies other than to permit months of bed rest at full pay, or to permit all soldiers sufficient time to properly care for their families following delivery. One of the foremost military sociologists, Charles Moskos, recognized a need for a break in active military service after a pregnancy, and recommended "...a maternity furlough, with two or three (or perhaps more) years off. Such a furlough would involve a new form of reserve status, in which the women would have certain priority rights to reenter the active force. At the same time, a

mother's time on furlough would not be calculated as active-duty time in grade."¹¹ While a step in the right direction, this proposal falls short of meeting soldier and Army requirements for the 21st Century.

The Family and Medical Leave Act of 1993

No Department of Defense military service currently offers a maternity or family care leave. Civilian employees of the Department of Defense, however, do have the option to participate in the Family Medical Leave Act (FMLA) of 1993. This is essentially a federally mandated program of up to 12 weeks of unpaid leave to care for a newborn, a dependent, or oneself in the event of a serious medical condition.

Although this policy may not be ideal or even sufficient for the Army individual or family, given the physical nature of military service, it is a form of competition for retention. Admittedly, it is a government mandated program, but private employers can improve upon it for their own employees. The government provides the program for it's own civilian, Senate, and House employees, but not for the military. What then can the military do to take care of its own?

¹¹ Moskos, Charles C. & Frank R. Wood. *The Military – More Than Just a Job?* Washington, D.C.: Pergamon-Brassye's, 1988, pp. 285-286.

U.S. Military Practices and Policies

The Army, Navy and Air Force are comparable in their policies (See Appendix A). All provide:

- a. exemptions from physical fitness and testing during antenatal and postpartum periods
- b. duty restrictions at specified times in a pregnancy
- c. mandated return to duty at 6 weeks postpartum
- d. deferred deployments until 4 months postpartum
- e. varied grace periods until the initial postpartum fitness test
- f. no breastfeeding policies

The Marine Corps is similar, but reserves all duty restrictions to the decision of the Marine's medical officer. None of the services authorizes a maternity leave period, with the exception of the 6 week postpartum convalescent period, and the service members receive pay and benefits, to include full medical care throughout the pregnancy and postpartum periods. Duty limitations and restrictions vary by individual and the progress of the pregnancy and recovery. The service member could theoretically be in a non-duty status for less than 6 weeks (in the case of a Marine) or for more than a year in the event of a difficult pregnancy, and all with full pay and allowances.

USCG Separation for the Care of Newborn Children

In response to perceived needs within its active duty force, the United States Coast Guard, on the recommendation of the 1990 "Women in the Coast Guard Study Group,¹² has "...established policy and procedures to allow officers and enlisted members a one-time separation from active duty for up to two years to discharge parental responsibilities to care for newborn children (CNC). The policy applies to either parent and includes legally adopted newborn children."¹³

In essence, the policy provides both officers and enlisted personnel a complete separation from the Coast Guard for a service member specified period of time, not to exceed 2 years, with no pay, benefits, time in service, or medical coverage. The service member incurs no obligation, as there is no repayment required, and essentially returns to the service at the career status they left. There is a guarantee of reenlistment or new officer appointment provided the returning service member can meet physical standards and security clearance requirements, however, there is no guarantee that the returnee will receive a choice of assignments or locations.

The option is approved at Coast Guard Headquarters, and is not available to first term service members with less than 4 years of service, those with a remaining active duty service obligation or those who are retirement eligible. Officers requesting a CNC separation must be career officers (minimum of 5 years with no break in service) and enlisted personnel must also be career

¹² Kane, LCDR Michelle. "Care of Newborn Children Policy." Unpublished Brief. 30 October 1998.

¹³ U. S. Department of Transportation. United States Coast Guard Personnel Manual. Washington, D.C.: Chapter 12.F.

oriented as noted above. All service members must be in good standing. The service member must request the separation at least 6 months in advance and request reinstatement 6-12 months prior to the intended return date. Both acceptance of the separation and return to duty are based upon the needs of the service.

The program is fairly new, and data are still being collected. Conversations with personnel who oversee the program indicate that a few more women than men participate in the program (121-100), and that the return rate is slightly higher for men (~ 60%) than women. Since the CNC is a separation from the service program, return is an option dependent upon the former service members' desires and the needs of the service. There has not been sufficient time within the program to note if there is any impact on promotion potential for those who participate in the CNC.¹⁴

The Coast Guard policy is new and it is a watershed program. They are even looking at expanding the policy to include family care for any reason, as in a sabbatical leave. A distinct limitation of this program is that the service member who chooses the separation option must have an additional source of support for medical care and daily living expenses. This could create a significant hardship for some, or negate the option of the program. It is also not available at the present time for those young enlisted and officer personnel who have the highest pregnancy rates.

¹⁴ Conversation with LCDR Michelle Kane and LT Ricardo Rodriguez, HQ, USCG, Personnel Command, Washington, D.C., 8 Dec 1998.

Allies/Foreign Military

A number of allied and foreign services are instituting parental leaves of absence for their service personnel in approximately the same manner as they do for civilians. One system most readily available, but admittedly complicated, is the Canadian Forces model.¹⁵ In the Canadian Forces, where personnel offices are combined and all services are subject to equivalent regulations, the military maternity leave and pay systems are intertwined with civilian Employment Insurance benefits to military personnel. Either parent can request up to 10 weeks of paid leave or a combined total of 10 weeks if both use the benefit. In addition to this, the mother is authorized a maximum of 17 weeks (119 days) of leave, leave without pay, annual leave, or accrued leave. Sick leave, equivalent to our postpartum leave, is included in the 17-week period. The computation is extremely complicated, but the benefits are there for the child and both parents. There is even the option, given sufficient time, to provide for replacements from the Canadian Reserve Forces. This option for reserve component fill for a soldier on maternity leave was also proposed by an American Army officer as a Strategy Research Project.¹⁶ A review of that possibility with the Personnel Office within the Office of the Chief, Army Reserve, revealed that it would not be fiscally possible unless the active Army would assume the costs of the replacement. It would also create significant turbulence in both the active

¹⁵ Canadian Forces. "Baby on the Way! Pregnancy in the Canadian Forces". National Defence. DGPA Creative Services, 97CS-2374.

¹⁶ Christ, Linda D. LTC, U.S. Army. "Parental Leave of Absence: Time for the Next Step". USAWC Strategy Research Report, March 1998.

and reserve units to identify, institute PCS procedures, and train-up a specific replacement for a short interim period.¹⁷

Army Policy Precedent

There is precedent also within the U.S. Army for a maternity leave policy.¹⁸ The United States Military Academy (USMA) at West Point, NY has published a policy memorandum that addresses both maternal and paternal issues and responsibilities, with regard to medical, legal, psychological, and optional religious and moral aspects. The Academy takes great care to ensure that a pregnant or possibly pregnant cadet is afforded all opportunities for counseling in all of the areas noted above. The chain of command is utilized throughout the decision making process for the cadets, and the cadets are also cautioned and reminded throughout the medical, counseling and decision processes that administrative privilege exists and their privacy will be protected. Therefore, no data is available on the success of this program. One would hope and presume that as much care is taken in the education of both male and female cadets with regard to preventing unwanted pregnancies.

The pregnant cadet is then offered the option of a one-year medical leave without pay or unqualified resignation. Medical personnel will monitor the progress of pregnant cadets who select neither option to determine their fitness to continue as a cadet. The Superintendent may direct a medical leave, for up

¹⁷ Interview with LTC R. Mark Prevette, OCAR, Washington, DC, 8 Dec 98.

to one year, for those who make no selection, based upon their ability to perform all cadet duties. The paternal cadet, if such is the case, is also offered counseling, but not the option to take a medical leave to accomplish his legal responsibilities, particularly since he is subject to separation for incurring the legal responsibility of a dependent.

Some cadets are older and better educated than a number of Army enlisted personnel and possibly some junior officers as well. Admittedly, the Military Academy is a unique environment within the Army, but if we can provide these options to cadets, could we not expand upon this for other active duty service members?

18 United States Military Academy. "Subject: Procedures and Instructions in Cases of Cadet Pregnancies." USMA Policy Memorandum Number 21-98. United States Military Academy, West Point, NY, 16 July 1998.

NEED FOR POLICY CHANGES

The Army invests a considerable amount of time and money training personnel to perform their military duties. For first-termers, one must include the cost of recruiting a soldier, costs incurred in basic, advanced and specialized skill training, plus leave, holidays, basic pay, allowances and benefits when computing total Army expenditures for developing soldiers and officers. The cost to the Army to educate and train career soldiers rises significantly. Thus, the Army spends a great deal of its decreasing training dollars on individual development of both first-term and career soldiers. We cannot afford not to get full benefit of these training dollars by keeping these soldiers in the Army and productive; the first-termers for the full duration of their contracts, and the careerists for a minimum of 20 years.

One of the major causes of loss of productive work time for women soldiers is pregnancy. In some instances, depending on the individual and the duty situation, a pregnant soldier can function effectively through the term of pregnancy, deliver uneventfully, and return to full duty immediately following maternity convalescent leave. For others, the situation can become much more complicated and result in a year or more of lost productive duty time.

Pregnancy

When a first-term soldier becomes pregnant, more than half of her enlistment could be served in a non-duty status. While catastrophic injuries and disabilities to older relatives can occur at any stage in a soldier's life, statistics on pregnancy show that the highest numbers and percentages of pregnancies occur in junior enlisted women, E1 – E4, and officers in grades O2 and O3. These grades, consisting of trainees, privates, specialists, lieutenants, and captains, correspond to the primary child bearing years. It is important to note, however, that military women, as a group, are not taking advantage of the service or the medical system as their pregnancy rate is lower than that of the general public. In fact, they become pregnant at rates significantly lower.¹⁹

If women were distributed equally among all Military Occupational Specialties (MOS's) and units, there might be little noticeable impact. However, since women are restricted from combat MOS's and positions with a high probability of combat or closing with the enemy, their proportional representation in combat support and combat service support units is increased. Therefore, while the average pregnancy rate throughout the Army as a whole varies from 6-15%, in some units, such as those with a higher than average concentration of young, junior enlisted, female personnel, as in petroleum units, the percentage of pregnant service women can vary from 10% to almost 30%.²⁰

¹⁹ Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press, 1998, p. 135.

²⁰ Conversation with MAJ J. Lechner, HQDA, ODCS PER, 9 Dec 1998.

Unintended Pregnancies

Another statistic that is of great concern to individual units, the Army, both military and civilian health care professionals, and the pregnant women, is the number of unintended pregnancies and pregnancies occurring in single women. Studies have reported that more than half of all pregnancies in the United States are unintended.²¹ Military statistics are equivalent. In a recent study conducted at Madigan Army Medical Center, researchers found that more than 55% of soldiers in prenatal care had unintended pregnancies.²² It is also probable that the incidence of unintended pregnancies was even higher since they estimated that more than half of the unintended pregnancies were aborted, and those who reported for medical care had already decided to carry to term. These "...unintended pregnancies may have an important, detrimental effect on both quality of life of soldiers and military readiness."²³

Problems associated with unintended pregnancies include "inadequate prenatal care...low birth weight...higher risk for poor school performance, abuse, and neglect."²⁴ Obviously, these problems would result in greater requirements for care of these children during their lifetimes. To complicate the issue even further, it was noted that "[u]nintended pregnancy was significantly associated with lower rank, younger age, single marital status, lower income, lower

²¹ Evans, Mary Ann, CPT. "Generalizability in Pregnancy and Work Research." *Military Medicine* 163, no. 5 (May 1998): [304-306].

Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998), p. 444.

²² Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998), p. 444.

²³ Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998), p. 444.

education level, and involvement in a relationship of less than 1 year's duration.²⁵ This corresponds to the statistic that "[t]he majority of junior enlisted soldiers reported that their pregnancies were unintended at the time of conception, with the highest percentage (82%) occurring among the most junior soldiers (E1 and E2)."²⁶ It would appear that we are not adequately preparing our young soldiers to meet the realities of Army life. We can and must do a better job of educating our young soldiers: throughout all levels of training; upon reporting to each new unit; and at each level of leadership training.

Single Parenthood

Another negative aspect of this issue is that unintended pregnancies are so closely associated with the factor of single parenthood. A recent Rand study noted that single motherhood was one of the three causes most often mentioned as the cause of lost duty time.²⁷ The Rand study further noted that "[s]ingle, pregnant, junior enlisted personnel were considered the most problematic because the pregnancies were less likely to be planned and more likely to create other problems, such as financial and child-care problems, that impacted the unit."²⁸

24 Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998), p. 444.

25 Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998), p. 445.

26 Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998), p. 445.

27 Harrell, Margaret C. and Laura L. Miller. "New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale." Washington, DC: Rand, 1997, p. 39.

28 Harrell, Margaret C. and Laura L. Miller. "New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale." Washington, DC: Rand, 1997, p. 40-41.

Although the percentage of single mothers is higher and, evidently, more visible, there are actually more male soldiers who are single parents.²⁹ This is another indication of the growing role male soldiers are taking in family care. Further, a compilation of research reported that parents, *per se*, lost equivalent amounts of time from the duty day for children related issues; there was no difference in the amount of lost work time between male and female parents.³⁰ Highlighting this equality between both male and female single parents, another study reported that “[s]ingle parents of either gender were perceived to place a burden on the unit.”³¹

It does not appear, however, as though single parenthood itself is as much the primary issue as is single female parenthood or pregnancy. In the Madigan Army Medical Center study, the authors reported that less than half (48%) of all junior enlisted soldiers (E1-E4), and only 36% of the lowest ranks (E1-E2) were married. Single female parents are less numerous, but seem to be more visible to others, perhaps because of the higher percentage of women than men who are single parents, or perhaps, too, because pregnant soldiers are very visible in units, whether in civilian clothes, maternity class “B” uniforms or, especially, BDUs. Whether it is perception or reality, the visibility of pregnant women becomes a morale factor, and generally a negative one. The research, as noted earlier, supports the contention that it is perception or bias and not reality, since male and female parents lose an equal amount of duty time daily.

²⁹ Verdugo, Naomi. “Overview of the Military Woman”. In *Assessing Readiness in Military Women*. Institute of Medicine. National Academy Press. Washington, D.C., 1998, p.216.

³⁰ Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press, 1998, p. 136.

³¹ Harrell, Margaret C. and Laura L. Miller. “New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale.” Washington, DC: Rand, 1997, p. 40.

Single parenthood and how it is handled are growing issues that affect quality of life, unit readiness and unit morale, and is perhaps another area that could be improved with education and a family medical care leave policy change.

High-Risk Pregnancies

Researchers and the military have determined that “[p]regnancy is compatible with a military career”.³² In the next breath, however, others report that any active-duty pregnancy is in a high-risk category.³³ Even though military women have greater access to medical care, at virtually no cost to the individual, and have specific duty limitations, it appears as though active duty women are at a higher risk for complications.³⁴ A number of factors have been identified as possible precursors to high-risk pregnancies: work environments; long hours; heavy lifting; chemical exposure; fuels; noise; paints; x-rays; electric shock; radiation; requirement to maintain height-weight standards; lack of social support; young age; psychological stress; and the likelihood of an unplanned pregnancy.³⁵

Military women are subject to many of these risk factors on a routine basis, and this is significant because high-risk pregnancies generally result in

32 Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998, p. 150.

33 Correnti, CPT Elizabeth E., MC and MAJ Peter S. Jensen, MC. "Support of the Pregnant Soldier in the Workplace: A Comparison of Her Assessment with That of Her Supervisor." *Military Medicine*. 154, no. 11 (November 1989): [571-573].

Fox, MAJ Murray E., MD, COL Robert E. Harris, MD, PhD, and COL Alvin L. Brekken, MD. "The active-duty military pregnancy: A new high-risk category." *American Journal of Obstetrics and Gynecology*. 129, no. 6 (November 15, 1977), p. 707.

Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998.

Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998) [408-412].

Magann, E.F. and Nolan, Thomas E. "Pregnancy Outcome in an Active-Duty Population." *Obstetrics & Gynecology*. 78, no. 3 (September 1991): [Part 1, 391-393].

34Magann, E.F. and Thomas E. Nolan. "Pregnancy Outcome in an Active-Duty Population." *Obstetrics & Gynecology*. 78, no. 3 (September 1991): [Part 1, 391-393].

Messersmith-Heroman, Karen, RN, CAPT Thomas R. Moore, MC, and CAPT William M. Heroman, MC. "Pregnancy Outcome in Military and Civilian Women." *Military Medicine*. 163, no. 8 (August 1998): [577-579].

more medical intervention, longer periods of time away from the unit, and greater stress on the unit, individual and family.

Research also points to three main psychological stressors evident in high risk pregnancies: "...lack of social supports, the pressures of minority status, and the institutional reactions to gender roles."³⁶ Research notes that in addition to creating physical problems during gestation, psychological stress also appears to be positively correlated with intention to leave the military.³⁷

Breastfeeding

Although the practice of breastfeeding is periodically popular with the general public, medical experts agree that it is the most beneficial method of sustenance for the infant and the mother. The American Academy of Pediatrics, and obstetricians, gynecologists and pediatricians as a group, acknowledge that breastfeeding an infant is the preferred method of feeding "...with respect to infant nutrition, gastrointestinal function, host defense, and psychological well-being, as well as to maternal health."³⁸

Military researchers, referencing civilian data, have also noted the beneficial effects of breastfeeding and have recommended it for Army mothers.³⁹ Among the beneficial effects for the mother is the relationship to postpartum

35 Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998.

36 Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998), p.408.

37 Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998.

38 Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998, p.147.

39 Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998, p.151.

weight loss. "In fact, breastfeeding usually promotes weight loss" ⁴⁰ and 6 of 7 quantitative studies indicated that breastfeeding was related to greater weight loss or lowered maternal weight retention.⁴¹ It is important to note here that exercise does not affect the quantity or quality of breastmilk available to the infant, nor does breastfeeding interfere with exercise. Return to a pre-pregnancy weight and fitness level is key to returning to full duty status within the time allotted, and will be discussed further in the section on education and pregnancy fitness.

Unfortunately, the practice of breastfeeding has not been studied in military women, and there have been no military studies on the "...impact or potential impact of breastfeeding on readiness." ⁴² What was reported extensively in all of the military trade papers, however, was a very visible series of articles on one breastfeeding Army mother and West Point graduate. A pilot, she sought to leave the service, without compensation for her education and flight training, because she felt she had not been given ample opportunity to breastfeed her child.⁴³ Ultimately, she was released from the service and was ordered to reimburse the Army for "some" of the costs of her education and training.⁴⁴ Because she felt she was not permitted sufficient time to breastfeed her daughter, a quality of life issue, the Army lost a very expensively and

40 Dewey, Katherine G. "The Impact of Pregnancy Weight Restrictions, Postpartum Exercise, and Weight Loss on Lactation." In Assessing Readiness in Military Women. Institute of Medicine. National Academy Press. Washington, D.C., 1998, p249.

41 Dewey, Katherine G. "The Impact of Pregnancy Weight Restrictions, Postpartum Exercise, and Weight Loss on Lactation." In Assessing Readiness in Military Women. Institute of Medicine. National Academy Press. Washington, D.C., 1998:[247-249].

42 Institute Of Medicine. Assessing Readiness in Military Women. Washington, D.C., National Academy Press, 1998, p.148.

43 Christ, Linda D. LTC, U.S. Army. "Parental Leave of Absence: Time for the Next Step". USAWC Strategy Research Report, March 1998.

Addie, Nick. "Pilot's Breast-feeding Case Takes a New Turn." Air Force Times. 12 May 1997, p. 11.

Addie, Nick. "Breast-feeding Issue Isn't New, Author Says." Air Force Times. 24 March 1997, p.11.

Addie, Nick. "Former Pilot Loses Lawsuit For Time Off To Breast-feed." Air Force Times. 27 Oct 1997, p.6.

44 Addie, Nick. "Cuevas Let Go From Army/Breast-feeding Black Hawk Pilot Must Repay Education Funds." Air Force Times. 27 Oct 1997, p. 8.

intensively trained female officer, and most of the money spent educating and training her.

Pregnancy and Unit Readiness

One of the major and legitimate concerns regarding pregnancy and Army women is that pregnancy will have a significant impact upon unit readiness. An average pregnancy rate of 6.5% throughout the Army is not considered a problem, and, as mentioned earlier, is actually lower than the pregnancy rate in the general population. However, concentrating pregnant personnel in specific units can be problematic. While studies over time have shown that integration of women into line units poses little or no problems, "(e)ffects on readiness do occur. For example, pregnancy can affect the availability of women. The effect is greater when the unit has many women or when it is understaffed; therefore, the limitations pregnancy imposes are both more visible and have a disproportionately greater effect."⁴⁵

An obvious and severe example of this occurs in MOS 77F, Petroleum Supply Specialist. This is a relatively 'flat' MOS, one where the majority of required positions are concentrated at one level with little opportunity for advancement. As a logistics MOS, 77F has a predominance of junior enlisted female personnel, an average of 45%. This population becomes even more concentrated at the divisional and corps levels since nearly 30% of all available

77F positions are coded 'male only' for combat units below division level. The combination of junior enlisted rank, lower age, and preponderance of available positions statistically increases the average pregnancy rate to nearly 20%. One must also consider that handling fuel, and extensive time spent in a fuel fume environment, are hazardous to the fetus. This necessitates removing pregnant soldiers from this environment immediately upon diagnosis of pregnancy.

Admittedly, there are other MOS's, such as those involving primarily office-type work environments, i.e. administration, legal, finance, or medical other than combat medic or operating room technician, where this situation would not reach a critical level. With 77F, the problem can be very critical.

Combining the duration of a normal pregnancy with normal postpartum convalescent leave can mandate that a pregnant 77F will be lost to her unit for the better part of a year! Because this soldier is still assigned to a unit, the unit cannot request a replacement. A pregnancy rate that averages nearly 20% for this MOS, and that has been as high as 30% in some units, has a significant impact on unit readiness. In this situation, pregnant soldiers can be "...detrimental to unit readiness through nondeployability, activity limitations, lost duty time, and unit morale effects."⁴⁶

When time consumed with leave, training, training holidays, a routine pregnancy and postpartum care is considered, a first-term soldier, such as a 77F, who becomes pregnant can have an effective 'productive' military service of only 17 out of 36 months. A difficult pregnancy and postpartum period would

⁴⁵ Harrell, Margaret C. and Laura L. Miller. "New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale." Washington, DC: Rand, 1997, P. xvii-xviii.

necessitate an even shorter productive term of service. In fairness to the Army and the American taxpayer, because the Army has contracted for a specific time period with those who take the oath to serve, it would seem only equitable that the soldier serve productively for that specified time.

It may even be more detrimental to a unit to lose a senior NCO/officer for an extended period of time due to a complicated pregnancy. At the present time, and under current policies, a commander cannot request a back-fill or replacement for a soldier on an extended pregnancy or convalescent leave. The soldier is still considered a part of that unit and is counted against unit strength. Whether the loss is a number of lower ranking women simultaneously, or a key senior woman, the loss can be significant to the unit. The capability of that individual or individuals is lost to the unit and others must compensate with time and effort. This in turn places a stress on the individuals who are doing 'double duty', the unit effort and unit morale.

Changes to the current policy are definitely needed if we are to reduce the negative effect pregnancy has on readiness, morale and gender relationships. But policy change alone is not sufficient. We must reduce the number of unintended and unwanted pregnancies and better prepare all soldiers to be responsible parents. To accomplish this, soldiers must receive reliable information related to pregnancy, bearing children, and how a child, or children, will affect their lives and careers. One very effective way to do this is through education.

⁴⁶ Smith, Paul N. "Clinical Impact of U.S. Army Policies and Procedures on Pregnancy, the Postpartum Period, and Body Composition: Twenty Years of Experience." In *Assessing Readiness in Military Women*. Institute of Medicine. Washington, D.C.: National Academy Press, 1998, p. 246.

EDUCATION

The educational requirements envisioned as part of a total pregnancy program should encompass specific programs of instruction (POIs) directed to initial entry training, sustainment training, reporting to a first or new duty assignment, and upon determination of pregnancy. An exportable type educational package should include topics on: conception, sexually transmitted diseases (STDs), Human Immunodeficiency Virus (HIV), family planning, unintended pregnancies and consequences, contraception, pregnancy options, pregnancy fitness (prenatal/postpartum), finance, nutrition, breastfeeding, and child care.

At the present time, no consistent and comprehensive educational package that can accommodate various ranks and career stages has been developed. However, "...given the high rates of unplanned pregnancies among military women, there appears to be a need for education and counseling for all service members on effective birth control and the importance of timing a pregnancy in one's military career".⁴⁷ Apparently, senior NCO's and officers, generally having more maturity and a better understanding of and commitment to the Army, show a greater propensity to plan their pregnancies around assignments and training events to have a minimal effect upon their units. A visible example of this is the number of pregnancies of young, mid-level officers attending the Command and General Staff Officer's Course. A Navy study also

showed a significant correlation between rank and pregnancy planning.⁴⁸ The combination of reproduction education with career development and planning could add to job satisfaction, improved quality of life for military families, and Army retention, as well as reduce the effect of pregnancy on unit readiness.

This must, however, be a concerted effort and not a 'check the block' one time event. The education program must involve the entire chain of command, unit, and installation. "To reduce attrition and enhance military readiness, all supervisory staff need increased training and education regarding pregnancy policy and treatment of pregnant personnel."⁴⁹

Unintended Pregnancies

The Committee on Unintended Pregnancy of the Institute of Medicine, "...urges, first and foremost, that the nation adopt a new social norm:

- **All pregnancies should be intended – that is, they should be consciously and clearly desired at the time of conception."**⁵⁰

Army medical personnel have recognized the tremendous need for pregnancy education. With regard to one aspect of the total program, unplanned pregnancies, the Madigan Army Medical Center, Ft. Lewis, WA, with Dr. (LTC) Diane M. Flynn as Principal Investigator, has developed a three-hour long

47 Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press1998, p. 150.

48 Evans, Mary Ann and Leora Rosen. "Pregnancy Planning and the Impact on Work Climate, Psychological Well-Being, and Work Effort in the Military". *Journal of Occupational Health Psychology*. 2, (No. 4, 1997): [353-361].

49 Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press1998, p. 150.

50 Brown, Sarah S. and Leon Eisenberg, eds. *The Best Intentions*. Washington, D.C.: National Academy Press, 1995, p.3.

exportable package: Unintended Pregnancy Prevention Program (UPPP). This package includes a videotape accompanied by printed material to assist any installation to begin its own unplanned pregnancy prevention program. The videotape, featuring military personnel of both sexes and various grades, includes the following information:

1. Unplanned pregnancy statistics
2. Family planning
3. Why couples take chances
4. Menstrual cycles
5. Birth control methods
6. Sexually transmitted diseases
7. Choosing a birth control method

The accompanying printed material (See Appendix C) includes:

1. Recommendations on how to initiate the program
2. A facilitator's guide
3. A command briefing
4. A worksheet for lesson participants
5. Evaluation forms
6. A data sheet on the advantages/disadvantages of various forms of contraceptives

Dr. Flynn and the other Madigan researchers are currently forwarding surveys to class participants to determine if there is an improvement in the unintended pregnancy rate compared to those who did not take the class. The

data is currently being analyzed, and the results will be available in the near future.⁵¹

While this effort at Ft. Lewis deals with a significant portion of the total educational requirement - unintended pregnancies - responsibility for a comprehensive education program should encompass several interest areas and include a number of affected organizations: Training and Doctrine Command (TRADOC), United States Army Medical Command (USAMEDCOM), United States Army Center for Health Promotion and Preventive Medicine (USACHPPM), the Office of the Surgeon General, the Office of the Deputy Chief of Staff Personnel, the Office of the Chief of Chaplains, and individual branch schools.

Finally, it is extremely important that financial realities and career decisions are included in any education program. Very often, young soldiers are completely unaware of the expense involved in having children, even if, as so many of them assume, medical care is free. In an effort to accommodate single pregnant soldiers and lessen the financial impact for them, in many locations commands move them to the head of family housing lists. Often this is accomplished to the great irritation of married soldiers, who must sometimes wait for long periods of time to be assigned family housing. This priority assignment system for single pregnant soldiers has a very negative effect on morale and becomes a significant quality of life issue for married soldiers. All need to be made aware of the consequences of pregnancy before they become pregnant or engage in behavior that could lead to single parent pregnancies.

⁵¹ Dr. (LTC) Diane Flynn, Madigan Army Medical Center, telephonic message, 241143Feb99.

Pregnancy Fitness

One aspect of all pregnancies that can be improved is prenatal and postpartum fitness. Usually when pregnancy and fitness are discussed simultaneously, it is to provide profiles and physical training (PT)/Army Physical Fitness Test (APFT) limitations. However, based on current civilian research, medical personnel are now encouraging and attempting to educate pregnant women to continue or initiate safe fitness programs during the prenatal and postpartum periods to enable the soldiers to return to pre-pregnancy weight and fitness levels more quickly and effectively.

The research shows that "...there are plenty of good reasons for women to be active, within reason, during pregnancy. Though exercise doesn't guarantee a problem-free pregnancy or labor, the benefits include less weight gain and prevention or control of gestational diabetes. In the delivery room, exercise provides greater strength, flexibility, endurance, and stamina and portends less need for augmentation of labor and fewer signs of fetal distress."⁵² Women who exercise also tend to deliver earlier, require less medical intervention, have shorter periods of labor, and a decreased probability of operative delivery (forceps or cesarean section).⁵³

To put it very simply, women who exercise on a regular sustained basis before and during pregnancy "...should enhance the course and outcome of the

52 Schrimming, Lisa. "What's New in Treating Active Women." *The Physician and Sportsmedicine*. 25, no. 7, July 97.

53 Clapp, James F. "The Effect of Continuing Regular Endurance Exercise on the Physiologic Adaptations to Pregnancy and Pregnancy Outcome." (Third IOC World Congress on Sports Sciences). *American Journal of Sports Medicine*. 24, no.6 (Nov-Dec 1996): [28-29].

pregnancy for both the mother and fetus.⁵⁴ It seems indisputable then that a concomitant benefit from the Army Physical Fitness Training program appears to be an improvement in the course of pregnancy, delivery and postpartum experience. However, because of the additional physiological stress of pregnancy, some careful guidelines must be followed and trained personnel must conduct any Army pregnancy physical fitness program.

The guidelines for a pregnancy physical fitness program developed by one physician and researcher are noted below. They also conform to the revised guidelines presented by the American College of Obstetrics and Gynecology.

While the Army as a whole does not have a comprehensive and coordinated pregnancy and postpartum fitness program, various elements have recognized the significance of the issue and have developed some germinal programs. There are some military installations and commands that have established information programs (i.e. the Female Soldier Readiness program managed by CPT Tiffany Vara, USA MEDDAC Alaska, Ft. Wainwright, AK 99703. (907) 353-5506, available on the Internet at <http://www.alaska.amedd.army.mil/female/>), and other installations (approximately 40% of Army installations)⁵⁵ and units that have developed local fitness programs of some type.

What the Army needs is a concerted effort to establish pregnancy and postpartum fitness programs at all installations and units. MAJ Mary Jo Lauren, an Army Physical Therapy Staff Officer at the United States Army Center for

⁵⁴ Clapp, James F. "The Effect of Continuing Regular Endurance Exercise on the Physiologic Adaptations to Pregnancy and Pregnancy Outcome." (Third IOC World Congress on Sports Sciences). American Journal of Sports Medicine. 24, no.6 (Nov-Dec 1996): [28-29].

Health Promotion and Preventive Medicine (USACHPPM), has undertaken the development of exactly that type of program (See Appendix D). The purpose of the program is “(t)o assist pregnant and post partum soldiers in maintaining fitness throughout their pregnancy and to assist them in returning to pre-pregnancy fitness levels after pregnancy termination.”⁵⁶ She recommends a program that garners the support of both the installation and tenant units' commanders, for funding, time, space, accountability, and data collection.

MAJ Lauren's criteria for a successful program include:

- Weekly educational classes provided by the Medical Treatment Facility during Physical Training (PT) time on a non-PT day
- Pregnancy PT conducted during unit PT time
- Pregnancy PT uniform
- Mandatory attendance
- Postpartum fitness program for at least 6 weeks post convalescent leave
- Certified instructors (Appendix D)

The continued development of this program and the data that results will be of great value to the Army. The participants, participating under medical supervision, can only benefit from what the program will provide to them and their families: increased maternal health, easier gestational periods, healthier babies, and a faster return to pre-pregnancy weight and fitness. Furthermore, it will allow

⁵⁵ Lauren, MAJ Maary Jo. "Pregnancy Fitness". United States Army Center for Health Promotion and Preventive Medicine, Briefing, undated.
⁵⁶ Lauren, MAJ Maary Jo. "Pregnancy Fitness". United States Army Center for Health Promotion and Preventive Medicine, Briefing, undated.

for earlier, healthier and more physically fit return to duty status, which in turn will help reduce the effects of pregnancy on unit readiness.

Table 1. Exercise Safety Tips for Pregnant Women

1. Fluid intake during and after exercise should be adequate to prevent dehydration and hypovolemia.
2. Clothing worn during exercise should allow for adequate ventilation and prevention of hyperthermia.
3. Exercise during febrile illness is contraindicated.
4. Supine exercise should be avoided, especially in the third trimester.
5. Exercises that require repetitive bouncing and jerky movements should be avoided, especially in the third trimester.
6. Recommended exercise regimens should emphasize low-impact activities, such as stationary bicycling, swimming, walking, and low-impact aerobics.
7. Activities that involve potential low-oxygen states, such as scuba diving and mountain climbing, are contraindicated.
8. The exercising pregnant woman should be encouraged to follow a diet that emphasizes complex carbohydrates to replace muscle glycogen lost during exercise, thereby minimizing the risk of fetal ketosis.
9. Participation in competitive team sports is acceptable in the first 15 weeks of pregnancy if the woman understands that there are potential but unproved risks for fetal loss from pelvic trauma, abdominal trauma, or both.
10. Exercises requiring significant use of Valsalva's maneuver, such as weight lifting, should be avoided, especially in the third trimester.

Reference: Araujo, David, MD. "Expecting Questions About Exercise and Pregnancy?" *The Physician and Sportsmedicine*. 25, no. 4, April 97. On-line. Available from <http://www.physportsmed.com/issues/1997/04apr/araujo.htm>

POLICY PROPOSAL

Any policy proposed or adopted must be one that incorporates the needs of the soldier and family member(s), as well as the needs of the Army, and the citizenry it serves; and which supports it financially. The policy must accomplish this with minimal disruption to unit readiness and with fairness to all soldiers: those who choose not to have children; choose not to combine career and family; are past child bearing age; or, are fortunate enough not to suffer catastrophic illness or injury in their families, or have older relatives with special needs. The policy should also "...avoid establishing double standards for men and women in the same positions and, where possible, eliminate double standards that exist now."⁵⁷

At the present time, postpartum soldiers are granted up to 6 weeks of convalescent leave. If necessary, a military physician can certify a longer postpartum convalescent leave. All soldiers accrue 30-days paid leave each year and can accrue, "save" and carryover up to 60 days of leave from one fiscal year to the next. Therefore, any requirement for absence from duty, for any family medical reason, for a period up to 90 days could be accommodated by current options: a combination of accrued leave and excess leave. Additionally, any maternity leave requirement that falls within the current allowance of 6 weeks

⁵⁷ Harrell, Margaret C. and Laura L. Miller. "New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale." Washington, DC: Rand, 1997, p. 102.

postpartum convalescent leave plus accrued and/or advance leave, in essence a time period of approximately 3 months, would not necessitate initiation or imposition of the family medical care leave. Any long duration period of care or convalescence, in excess of 3 months, cannot be accommodated by current policies and options, and would require the option of a family medical care leave.

Therefore, this paper proposes a specified period of time, from 3 months to one year (in addition to the current 42-day postpartum convalescent leave), as a sufficient time frame to accomplish initial bonding, adequate nursing, and arrangements for future child care for newborn or adopted infants. This leave time, determined by the soldier or the soldier under advice of a physician, would also be sufficient for arranging for and establishing primary care for older, ill, or disabled relatives. Currently there is no leave policy to deal with this growing need for elder or family care. This family medical care leave is another effort at improving the quality of life for service members.

Conditions of the Policy

Once the service member and family determine that a 3-month combination of regular and advance leave will be insufficient to meet their medical needs, the soldier can apply for an extended 3 to 12 months of family medical care leave. As envisioned, this leave provides the service member and family, full pay, allowances, and medical benefits for the duration of the leave. However, it does not permit time in service (TIS) or time in grade (TIG) credit

towards retirement pay or promotion, nor does the soldier continue to accrue regular leave while on family medical care leave status.

Approval for the first and second family medical care leave should reside with the first general officer in the chain of command. Approval must be dependent upon normal approval procedures, based upon quality of service of the individual requesting the leave, the potential impact upon the soldier's unit, and the needs of the service.

Upon approval of a family medical care leave, the soldier becomes a projected loss to the unit and the unit can then requisition the personnel system for a replacement upon the effective date of initiation of the leave. The soldier is then placed on the Temporary Disability Retired List (TDRL). Since the pregnant soldier will be under a doctor's care, and will have an anticipated date of return, there will be no need to periodically review the soldier's medical status. The review can be concurrent with an evaluation of fitness to return to duty or upon notification of any significant complication that would require a change in status.

In a manner similar to that for an educational leave, a family medical care leave would incur a 'two-for-one' payback in service time. Furthermore, once a family medical care leave has been granted, the service member can then be identified by personnel assignment managers for a return to duty position within the normal rotation based on a known availability date. The time that is required to payback an initial leave must be completed prior to initiating a second family medical care leave.

The next general officer in the chain of command must approve a third or subsequent leave. More than two family medical care leaves in a soldier's career should be discouraged. Approval for more than 2 cumulative years of leave must take into consideration a career service member's age, rank and years of service. Army service is a very active way of life, more suited to young and fit individuals. Consideration must be given to potential age upon completion of terms of service based on maximum time in service by grade and extension of service due to obligations arising from the family medical care leave. Other determinants will be MOS, grade level, position held, the progress of technology within the soldier's MOS, and requirements for retraining upon return from leave. Thus, there is a need for approval by the next higher general officer in the chain of command.

There should, of course, be a contractual agreement between the soldier and the Army. The contract must stipulate:

- a. the length of the family medical care leave desired
- b. agreement by the soldier to incur a service obligation equivalent to a period of service twice the length of the leave
- c. acknowledgement of the requirement to financially reimburse the Army/government, if the soldier does not return, for all moneys received from the start of the leave until the soldier notifies the Army of intent not to return (either unable or unwilling) and pay and benefits cease

As presented to this point, the initiation of a family medical care leave has been optional, for the convenience and benefit of the soldier and the Army. One must consider, at this point, that if the option of a leave is beneficial to the soldier and the Army, then the imposition of the leave, for similar periods of inability to perform military duties, must still be of benefit to the Army. Essentially, what this would accomplish is limiting the time a soldier can remain on a convalescent leave, without performing the duties for which he or she was trained, and still receive pay, allowances, and credit for time in service and time in grade. How long should the Army and the taxpayer be required to "carry" a non-performing soldier, particularly for a non-service connected disability or an injury classified as not occurring in the line of duty (Line of Duty – No)?

It is even possible to add a clause to the enlistment contract that would make imposition of the family medical care leave mandatory under equivalent periods of lost duty time; i.e. for any anticipated incapacitation longer than three months. It would require soldiers who:

- a. become pregnant in the first term of service
- b. cause a pregnancy which requires them to personally provide extended care
- c. acquire dependents needing extended care
- d. incur a self-inflicted or Line of Duty – No injury

but who choose not to take the family medical care leave, to leave the service and pay back the cost of their Army training to the government. This mandatory imposition of the new policy has the same benefits as the voluntary leave, with

the additions of lessened impact on the unit, on morale, on Army training dollars, and possibly, on the prevention, or at least reduction, of unwanted/unplanned pregnancies.

At the present time, in accordance with AR 635-40 Physical Evaluation for Retention, Retirement or Separation, we are proscribed from using the TDRL for convalescence.⁵⁸ However, a review of the regulation and philosophy for the policy could result in a revision of the regulation to accommodate this new family medical care leave policy.

The time payback for a family medical care leave, on a two day payback for each day of leave taken, equivalent to a funded education leave, begins the day the soldier returns to duty. A soldier can request an early termination to a specified leave period, but is dependent upon a designation of assignment for a return date. If soldiers determine, at any time during the leave, that they no longer wish to return to active duty, they incur an immediate financial obligation for the total amount of money received from the day the leave was initiated until the day it was terminated. In the event that a statutory requirement existed at the time the leave began, they are pecuniarily liable for the cost of that contractual agreement as well, i.e. enlistment contract, education leave, or flight training. These funds can be repaid to the government in installments.

58 Army Regulation (AR) 635-40, Physical Evaluation for Retention, Retirement or Separation, 1 September 1990.

RECOMMENDATIONS

Initiate family medical care leave program with a phased-in trial family medical care leave program beginning with physician designated high-risk pregnancies requiring extended bed rest or severely limited duty. In phase two, authorize dual status military families (both parents active duty military, regardless of service) to apply for the leave program. Finally, progress to phase three to include single parent soldiers and service members with a dependent, such as an elderly parent, who is ill. Evaluation of the effectiveness of the family medical care leave program is a basic requirement. A formal evaluation program should be developed that would encompass the impact of the program on unit readiness, morale, fiscal expenditures, soldier retention levels, individual career progression and promotion opportunities.

Provide a comprehensive, coordinated education program for all newly enlisted soldiers and officers, male and female, in basic training and at the officer basic courses. The program of instruction should include the following subjects: conception, sexually transmitted diseases (STDs), HIV, family planning, unintended pregnancies and consequences, contraception, pregnancy options, pregnancy fitness (prenatal/postpartum), finance, nutrition, breastfeeding, and child care. As noted in the Madigan Unintended Pregnancy Prevention Program, because some soldiers would be uncomfortable discussing some of the subjects in a coeducational setting, it would also be beneficial to conduct some

classes separately for men and women inductees; an additional "...orientation for women that accurately describes the handling of pregnancy-related matters is recommended for all female inductees".⁵⁹

The instructional sequence should be repeated upon inprocessing at a new duty station. The briefing could be modified appropriately for rank structure, and age, but there are common elements for all levels. It is also imperative that the instructional sequence be instituted at each level in the formal training process and in all professional leader development courses to ensure that all those assuming leadership positions will have access to the training. An educational program requires the knowledge and cooperation of the entire chain of command for it to be effective. It is important that the education program be repeated at all levels of training, because "Commanders who have years of experience in training young men should be educated in the differences between training men and training women, especially the reproductive aspects. And, because as we move into the 21st century women will be a vital resource for the all-volunteer force, it is recommended that steps be taken by military leaders to combat the effects of tokenism and sexism. In many ways, working mothers in the military are the prototypic working mothers, and as such they are highly visible."⁶⁰

Develop a concerted, scientific and professional military data collection effort in order to enhance the evaluation of this or any proposed policy to ensure that it is reasonable, effective, and even necessary. It is extremely difficult to

59 Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998) p. 412.

60 Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998) p. 412.

obtain data that pertains to pregnant soldiers. As it stands now, word of mouth, rumor and innuendo rule more than wisdom and fact. "Better information would clear up any misperceptions and identify areas where policies might be developed to minimize differences that do occur."⁶¹

An additional recommendation is to review coding of military medical and unit status reports to:

1. provide greater accessibility to pregnancy data;
2. determine actual lost duty time for pregnancy, other medical conditions, and parenthood;
3. determine the effects of pregnancy upon specific MOS's and career fields;
4. ultimately establish what, if any, correlation exists between pregnancy and readiness.

This information could be used to determine the actual, potential, or perceptual impact pregnancy has on readiness. For example, this information may be able to debunk the myth that soldiers get pregnant to avoid deployments and arduous duty. If you speak with some male soldiers or even read newspaper editorials, you will hear opinions about numbers of women getting pregnant to get out of deployments, including and especially the Gulf War. This thus far unsupported belief has a negative impact on morale and gender relationships. Furthermore, it is in direct contradiction with findings made by Dr. Verdugo, of the Office of the Deputy Chief of Staff for Personnel (ODCSPER). She has reported

⁶¹ Harrell, Margaret C. and Laura L. Miller. "New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale." Washington, DC: Rand, 1997, p. 101.

that there was a substantial drop in pregnancy rates during deployments.⁶² Valid and accurate data correlating deployment and pregnancy would reveal whether or not women as a group are getting pregnant to avoid overseas deployments and exercises, as is presumed by some personnel. Another explanation could be that some existing pregnancies are just not detected prior to deployment⁶³, and only as they progress later in the deployment are the pregnant soldiers medically identified and evacuated. Right now, we simply cannot say with certainty. The problem, as Verdugo noted, is that “[D]ata on pregnancy should be more readily obtainable. There is a common perception that women become pregnant to escape deployments, though the few studies I could find on this topic did not bear this out.”⁶⁴

Currently there are only differing opinions. With the limited data presently available, we cannot be sure if perceived differences, losses and privileges actually exist, or are merely a result of the greater visibility of the women soldiers.⁶⁵ Rigorous research could resolve the discrepancies. If independent research stated unequivocally that women are not trying to avoid deployments by becoming pregnant, that fact could aid in improving unit morale and gender relations. Also, if we can determine the effects on specific MOSs, changes could be made within an MOS (structure, grade, fill, recruitment, family medical care

62 Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press, 1998, p. 139.

63 Tam, Leslie W. MD “Psychological Aspects of Pregnancy in the Military: A Review.” *Military Medicine* 163, no. 6 (June 1998) p. 408.

64 Verdugo, Naomi. “Overview of the Military Woman”. In *Assessing Readiness in Military Women*. Institute of Medicine. National Academy Press. Washington, D.C., 1998, p.216.

65 Harrell, Margaret C. and Laura L. Miller. “New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale.” Washington, DC: Rand, 1997, p. 101.

leave) to improve conditions and reduce the negative effect of pregnancy on the unit.

Incorporate a standardized brief, upon a diagnosis of pregnancy, to all affected soldiers about the benefits derived from requesting leave under this policy and how it can be used by soldiers to care for their family members.

In the same manner, Chaplains and personnel in a soldier's chain of command could present the brief when counseling soldiers on care for catastrophic illnesses/injuries occurring to immediate family members or dependent older relatives. Knowledge of such a policy could enhance their opinion of what the Army is doing to care for the Army family, and even provide impetus for staying in the Army.

The current policy does not meet the needs of the 21st Century soldiers and their families. Whether this proposal for a family medical care leave act is implemented or some other, the policy for dealing with family medical care, especially in the area of pregnancy, must change. The changing face of the Army of the future – increased participation by women, greater concern for Quality of Life issues, and increased competition from the civilian work community - demands it. We must be proactive on this, or we will lose our best and brightest.

BIBLIOGRAPHY

Adde, Nick. "Pilot's Breast-feeding Case Takes a New Turn." *Air Force Times*. 12 May 1997, p. 11.

Adde, Nick. "Breast-feeding Issue Isn't New, Author Says." *Air Force Times*. 24 March 1997, p.11.

Adde, Nick. "Former Pilot Loses Lawsuit For Time Off To Breast-feed." *Air Force Times*. 27 Oct 1997, p.6.

Adde, Nick. "Cuevas Let Go From Army/Breast-feeding Black Hawk Pilot Must Repay Education Funds." *Air Force Times*. 27 Oct 1997, p. 8.

Araujo, David. MD. "Expecting Questions About Exercise and Pregnancy?" *The Physician and Sportsmedicine*. 25, no. 4, April 97. On-line. Available from <http://www.physsportsmed.com/issues/1997/04apr/araujo.htm>

Army Regulation (AR) 635-40. *Physical Evaluation for Retention, Retirement or Separation*, 1 September 1990.

Becraft, Carolyn H. "Military Women: Policies and Politics". *The Bureaucrat*. Fall 1991, p. 12.

Brown, Sarah S. and Leon Eisenberg, eds. *The Best Intentions*. Washington, D.C.: National Academy Press, 1995.

Canadian Forces. "Baby on the Way! Pregnancy in the Canadian Forces". National Defence. DGPA Creative Services, 97CS-2374.

Christ, Linda D. LTC, U.S. Army. "Parental Leave of Absence: Time for the Next Step". USAWC Strategy Research Report, March 1998.

Clark, LTC Jeffrey B., LTC Fred Miser, MC, and Victoria L. Holt, PhD. "Unintended Pregnancy among Female Soldiers Presenting for Prenatal Care at Madigan Army Medical Center." *Military Medicine* 163, no. 7 (July 1998): [444-448].

Correnti, CPT Elizabeth E., MC and MAJ Peter S. Jensen, MC. "Support of the Pregnant Soldier in the Workplace: A Comparison of Her Assessment with That of Her Supervisor." *Military Medicine*. 154, no. 11 (November 1989): [571-573].

Christ, Linda D., LTC. "Parental Leave of Absence: Time for the Next Step". USAWC Strategy Research Report, March 1998.

Evans, Mary Ann, CPT. "Generalizability in Pregnancy and Work Research." *Military Medicine* 163, no. 5 (May 1998): [304-306].

Evans, Mary Ann and Leora Rosen. "Pregnancy Planning and the Impact on Work Climate, Psychological Well-Being, and Work Effort in the Military". *Journal of Occupational Health Psychology*. 2, (No. 4, 1997): [353-361].

Evans, Mary Ann, PhD, CPT. and Leora Rosen, PhD. "Women in the Military: Pregnancy. Command Climate, Organizational Behavior, and Outcomes. Part I." HR 96-001, Part 1. Center for Healthcare Education & Studies, AMEDD Center & School, Ft. Sam Houston, May 1996.

Fox, MAJ Murray E., MD, COL Robert E. Harris, MD, PhD, and COL Alvin L. Brekken, MD. "The active-duty military pregnancy: A new high-risk category." *American Journal of Obstetrics and Gynecology*. Vol. 129, No. 6 (November 15, 1977): [705-707].

Gilcreast, D .M. LTC, et.al. "The Pregnant Soldier Wellness Program (PSWP) – An Evaluation: Preliminary Results." Research Grant, 1998.

Harrell, Margaret C. and Laura L. Miller. "New Opportunities for Military Women: Effects upon Readiness, Cohesion, and Morale." Washington, DC: *Rand*, 1997.

Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press, 1998.

Kane, LCDR Michelle. "Care of Newborn Children Policy." Unpublished Brief. 30 October 1998.

Laurin, MAJ Mary Jo. Pregnancy Fitness Programs. Information Paper, 13 Nov 98.

Magann, E.F. and Thomas E. Nolan. "Pregnancy Outcome in an Active-Duty Population." *Obstetrics & Gynecology*. 78, no. 3 (September 1991): [Part 1, 391-393].

Messersmith-Heroman, Karen, RN, CAPT Thomas R. Moore, MC, and CAPT William M. Heroman, MC. "Pregnancy Outcome in Military and Civilian Women." *Military Medicine*. 163, no. 8 (August 1998): [577-579].

Moskos, Charles C. & Wood, Frank R. *The Military – More than Just a Job?* Washington, D.C.: Pergamon-Brassey's 1988.

McCormick, David. "The Draft Isn't The Answer." *New York Times*, February 10, 1999. On-line. Available from <http://ebird.dtic.mil/d/htpd/ebird/Feb1999/e19990210.draft.htm>.

Schnirring, Lisa. "What's New in Treating Active Women." *The Physician and Sportsmedicine*. 25, no. 7, July 97. On-line. Available from <http://www.physportsmed.com/issues/1997/07jul/schnirri.htm>

Smith, Paul N. "Clinical Impact of U.S. Army Policies and Procedures on Pregnancy, the Postpartum Period, and Body Composition: Twenty Years of Experience." In *Assessing Readiness in Military Women*. Institute of Medicine. Washington, D.C.: National Academy Press, 1998: [246-247].

Tam, Leslie W., MD "Psychological Aspects of Pregnancy in the Military: A Review." *Military Medicine* 163, no. 6 (June 1998) [408-412].

Torchbearer Messenger. Association of the United States Army, No. 3, January 1999.

U. S. Department of Transportation. *United States Coast Guard Personnel Manual*. Washington, D.C.: Chapter 12.F.

United States Military Academy. "Subject: Procedures and Instructions in Cases of Cadet Pregnancies." USMA Policy Memorandum Number 21-98. United States Military Academy, West Point, NY, 16 July 1998.

Verdugo, Naomi. "Overview of the Military Woman". In *Assessing Readiness in Military Women*. Institute of Medicine. National Academy Press. Washington, D.C., 1998, Pp.215-216.

Walker, The Honorable Robert M. and General Dennis J. Reimer. *A Statement on the Posture of the United States Army Fiscal Year 1999*. Second Session, 105th Congress, February 1998.

Appendix A

U.S. Military Practices and Policies for Female Personnel: Pregnancy and Postpartum Periods⁶⁶

⁶⁶ Institute Of Medicine. *Assessing Readiness in Military Women*. Washington, D.C., National Academy Press, 1998, pp. 128-129.

TABLE 6-1 U.S. Military Practices and Policies for Female Personnel: Pregnancy and Postpartum Periods

Period	Army	Navy	Air Force	Marine Corps	Coast Guard
Pregnancy	<ul style="list-style-type: none"> •Exempt from body composition, fitness testing (AR 40-501, 1995) •Nondeployable •At 20 weeks, standing at parade rest/attention < 15 minutes •At 28 weeks, 40-h week/8-h day •40-h work week •Standing at parade rest/attention no more than 20 minutes 	<ul style="list-style-type: none"> •Exempt from body composition, fitness testing •20-wk Rule (no shipboard duty after 20th week of gestation) •6-h Rule (medical evacuation for ER must be within 6 hours) •OPNAVINST 6000.1A, 1989) 	<ul style="list-style-type: none"> •Exempt from body composition, fitness testing •Restrictions based on work environment •Pregnant members assigned to areas without obstetrical care will have assignment curtailed by 24th week (AFI 44-102, 1996) 	<ul style="list-style-type: none"> •Full-duty status and deployable until medical officer certifies that full duty is medically inadvisable •May not participate in contingency operations or be deployed for operations aboard Navy vessels •Flight personnel are grounded unless cleared by medical waiver •Excused from duties (physical training or standing in formation) that in the opinion of the medical officer are hazardous to her health or to her unborn child 	<ul style="list-style-type: none"> •Exempt from body composition testing •>28 weeks, 40-h work week; no overseas duty •Other duty restrictions based on work environment; no rescue swimmer duties •Not deployable during 20th week through 6 months postpartum •Time to medical evacuation for emergencies < 3 hours •No flight duties after 2nd trimester •Prenatal sick leave not to exceed 30 days

Postpartum	•Return to duty at 6 weeks	•Return to duty at 6 weeks	•Return to duty at 6 weeks (or as soon after delivery as medical officer certifies)
	<ul style="list-style-type: none"> •Exempt from weigh-in until 6 months •Physical training at own pace for 45 days •Exempt from fitness testing for 135 days (FM 21-20, 1992) •Deferment from deployment until 4 months postpartum •No policy regarding breastfeeding 	<ul style="list-style-type: none"> •Exempt from weigh-in until 6 months •Exempt from fitness testing for 6 months •Deferment from deployment until 4 months postpartum •Exempt from fitness testing for 6 months (AFI 40-502, 1994) •Commander may approve up to 18 months deferral •No policy regarding breastfeeding 	<ul style="list-style-type: none"> •Exempt from weigh-in until 6 months •Deferment from deployment until 4 months postpartum •Exempt from fitness testing for 6 months •Deferment from deployment until 4 months postpartum •Commander may approve up to 18 months deferral •No policy regarding breastfeeding

NOTE: AR, Army Regulation; OPNAVINST, Naval Operations Instruction; AFI, Air Force Instruction; FM, Field Manual; MCO, Marine Corps Order. A more detailed table appears in Appendix B.

For nursing mothers,

the 6-mo weight standards exemption following delivery will begin at the conclusion of the nursing period, but no later than 12 months postdelivery

•Exempt from weigh-in until 6 months

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Commander may approve up to 18 months deferral

•No policy regarding breastfeeding

•Exempt from weigh-in until 6 months

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Commander may approve up to 18 months deferral

•No policy regarding breastfeeding

•Exempt from weigh-in until 6 months

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Commander may approve up to 18 months deferral

•No policy regarding breastfeeding

•Exempt from weigh-in until 6 months

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Commander may approve up to 18 months deferral

•No policy regarding breastfeeding

•Exempt from weigh-in until 6 months

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Commander may approve up to 18 months deferral

•No policy regarding breastfeeding

•Exempt from weigh-in until 6 months

•Exempt from fitness testing for 6 months

•Deferment from deployment until 4 months postpartum

•Commander may approve up to 18 months deferral

•No policy regarding breastfeeding

Appendix B

United States Coast Guard

Personnel Manual Chapter 12.F.

SEPARATION FOR THE CARE OF NEWBORN CHILDREN (CNC)

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12.F. SEPARATION FOR THE CARE OF NEWBORN CHILDREN (cnc)

12.F.1. General

This section incorporates established policy and procedures to allow officers and enlisted members a one-time separation from active duty for up to two years to discharge parental responsibilities to care for newborn children (CNC). The policy applies to either parent and includes legally adopted newborn children.

12.F.2. Discussion

1. This policy implements a recommendation of the Women in the Coast Guard Study Group; at its heart are the notions of flexibility and choice. The emergence of dual-income and single-parent families, among other economic and cultural changes, has created the need for enhanced family care opportunities and greater Service flexibility. By providing a wider choice, the Coast Guard can help members balance careers and personal commitments and improve their quality of life.
2. Developed as a special retention program, this policy allows a member to separate with a guarantee of reenlistment or a new officer appointment on meeting physical standards. This policy is an extension of other policies which permit members to return to active duty after temporary absence; e.g., weight standards, temporary disability retired list.
3. A member separated under this policy will not receive any pay, allowances, or peripheral Service benefits such as retirement, medical coverage, or Serviceman's Group Life Insurance (SGLI) during the separation. An officer will lose precedence on the Active Duty Promotion List (ADPL); Commander, (CGPC-opm-1) will remove him or her from selection lists, if applicable. Commander, (CGPC-epm-1) will remove an enlisted member from the advancement list. On return to active duty, a member receives credit for time served in grade before the period of separation.
4. In the interest of implementing a policy responsive to the recommendations of the Women in the Coast Guard Study Group, the Service used existing personnel laws. References to various categories of officers and the procedures to effect an appointment are drawn directly from personnel law and intended to improve subsequent appointment to a former grade.

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5. This policy departs significantly from earlier personnel policies governing members' voluntary separation from the Service. Under previous policies, these members would have had no obligation and were not guaranteed a return to active duty to pursue a Service career. This policy is intended to improve the retention of valuable experienced members. It also prepares our organization to implement personnel practices to manage the future work force.
6. This policy establishes another significant element in the continuum of options available to our members in caring for newborn children, including adopted newborns.
 - a. **Maternity Leave**: Any female member may be granted up to 30 days cumulative prenatal sick leave without Headquarters approval. In addition, postnatal sick leave may be granted for up to 42 cumulative days. All sick leave must be certified as necessary by a physician. These periods of sick leave are for the member's care and convalescence.
 - b. **Maternity Leave Plus Regular Leave**: Any female member may be granted 42 days' postnatal sick leave plus 60 or more days (at the command's discretion) regular leave. This provides potential opportunity for over three months authorized absence from duty.
 - c. **Officer Resignation from Regular Status to Reserve Status**: Now available to officers, but with no guarantee of a **Selected Reserve Billet**, or **recall to active duty**. The member could be called to extended active duty as a Reserve officer with no loss of numbers.
 - d. **Separation from Enlisted Status Due to Hardship**: Now available to enlisted members based on providing evidence they are experiencing a bona fide hardship. A guarantee of reenlistment is not provided.
 - e. **Separation for Care of Newborn**: For career members who desire guaranteed return to active duty after discharge.

12.F.3. General Provisions

12.F.3.a. Separation

1. Commander, (CGPC-epm-1) or (CGPC-opm-1) may approve one request for up to 24 months of CNC policy separation in a member's career to care for a newborn child for whom the member assumes parental responsibilities.
2. All requests are considered based on a member's record and Service needs at the time of separation.

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3. An applicant with active duty obligated service is not eligible for CNC separation. Obligated service means a commitment of time due to some benefit a member received, such as training, tuition assistance, permanent change of station orders, advancement, or promotion, etc. In all cases, a member must have completed one year at his or her current duty station before his or her request will be considered. For these purposes, obligated service does not include an enlistment contract.
4. A prerequisite for separating from the Service under this policy is an approved physical under Chapter 3, Medical Manual, COMDTINST M6000 (series).
5. The member must submit his or her request at least six months before his or her requested separation date and state the intended date of return to active duty. In cases involving the adoption of newborn children, submit the request as early as possible; base the separation and return dates on the best information available. A member may submit a request when he or she is on an approved list for adoption with an adoption agency.
6. Retirement-eligible members may not apply for discharge under this policy.
7. The effective separation starting date under the policy should be within 12 months after the child's birth (including an adopted child). Using sick leave or annual leave before or after birth does not preclude eligibility for separation under the CNC policy.

12.F.3.b. Return to Active Duty

1. An approved request guarantees reinstatement to the same grade or rate at the end of the CNC separation, subject to physical qualification. The member must complete a physical examination at a U.S. Military Entrance Processing Station (MEPS) and meet initial entry physical standards. Waivers will be considered for conditions existing at separation which are not disqualifying under retention physical standards or do not prohibit worldwide assignment.
2. The applicant must submit a Notice of Intent in the format provided in Figure 12.F.3.1. at least six months and up to one year before the intended date of return to active duty.
3. Recruiters and Commander, (CGPC-CGRC), as necessary, shall assist each applicant in completing the processing file to return to active duty under the CNC policy. Officers returning to active duty under the CNC policy shall be processed under the procedures outlined in Figure 12.F.3.2.
4. An officer must initiate a National Agency Check before effecting the new appointment. As part of the Notice of Intent, the applicant signs the statement in Figure 12.F.3.1.

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5. In addition to the security check, any CWO (COMMS) who has separated from the Coast Guard for more than 12 months must have a favorable background investigation or update completed within one year of returning to active duty. As part of the Notice of Intent, the applicant signs a statement in Figure 12.F.3.1.
6. Enlisted members in ratings requiring security clearances must initiate a National Agency Check before re-enlisting. Also, if a rating requires, members must have a favorable background investigation or update completed within one year of return to active duty. Failure to qualify for the proper clearance will require the member to pursue a change in rating or he or she may be subject to separation from the Coast Guard. As part of the Notice of Intent, the applicant will sign a statement in Figure 12.F.3.1.

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Figure 12.F.3.1. NOTICE OF INTENT TO RETURN TO ACTIVE DUTY UNDER THE PROVISIONS OF THE CNC POLICY

From: (Applicant)

To: Commander, (CGPC-CGRC)

Subj: NOTICE OF INTENT TO RETURN TO ACTIVE DUTY UNDER THE
CNC POLICY

1. I hereby notify you I intend to return to active duty on [insert date] under the provisions of the CNC policy. I understand on return to active duty, I will enlist in or be appointed to the same grade or rate last held while serving on active duty.
2. I understand I must complete a physical examination. I will perform necessary travel to fulfill this requirement at my own expense with no cost to the Government.
3. I declare I am not drawing and do not have a claim pending for a pension, disability allowance, disability compensation, or retired pay from the United States Government.
4. **(OFFICERS ONLY)** I understand a National Agency Check will be conducted to determine whether I am qualified to hold a commission as a United States Coast Guard officer. If the check reveals I am not eligible for a security clearance, I may be subject to separation.

or

4. **(CWO COMMS ONLY)** I understand a Background Investigation will be conducted to determine whether I am qualified for appointment for the COMMS Warrant Officer specialty in the United States Coast Guard. If the check reveals I am not eligible for a favorable background investigation, I may be subject to separation.

or

4. **(ENLISTED ONLY)** I understand a National Agency Check or Background Investigation [as applicable] will be conducted to determine my qualifications for service in a United States Coast Guard rating. If it reveals I am not eligible for a security clearance, Commander, (CGPC-epm-1) may require me to pursue a change in rating or separate from the Service.

5. My current home address is:

Street Address

City, State, Zip

Telephone Number

Member's signature

Subscribed and Sworn to before me this [no.] day of [month], [Yr].

Notary Public/Coast Guard Officer

Copy: Commander, (CGPC-epm) or (CGPC-opm)

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Figure 12.F.3.2. SUBSEQUENT APPOINTMENT PROCESS FOR FORMER OFFICERS RETURNING TO ACTIVE DUTY UNDER THE CNC POLICY

1. The applicant must submit a Notice of Intent no less than six months and no more than one year before the intended date of return to active duty. Notice must be submitted to Director, Coast Guard Recruiting Center (CGPC-CGRC).  Article 12.F.3.
2. Within 30 days after receiving the Notice of Intent, CGPC-CGRC will advise the applicant of which recruiting office to contact to complete the appointment process.
3. Local recruiting offices shall arrange for persons CGRC-CGPC authorizes to undergo the physical examination at a U.S. Military Entrance Processing Station (MEPS) within 90 days before the date the applicant will be appointed to the former grade. The applicable recruiting office will also assist the applicant in completing the pre-appointment file.
4. The applicant will pay all travel expenses in determining eligibility for return to active duty, including appearance for the physical examination.
5. Except for the physical examination, the applicant must initiate the pre-appointment file within 30 days of receiving CGPC-CGRC's directions to contact a specific recruiting office for processing.
6. The recruiting office shall send the completed pre-appointment file (except the physical exam) to CGPC-CGRC within 45 days after receiving Notice of Intent to return to active duty.
7. The recruiting office will send the approved physical examination to CGPC-CGRC at least 45 days before the appointment date. Disapproved physical examinations must include all additional medical information for waiver consideration. CGPC-CGRC will send disapproved physical examinations and additional medical information to Commandant (G-WKH) for medical waiver recommendation. All persons must comply with the body weight and composition limits outlined in COMDTINST 1020.8 (series) before signing the Acceptance and Oath of Office.
8. CGPC-CGRC will review the complete file and advise Commander, (CGPC-opm) of the status of the National Agency Check and physical examination at least 30 days before the date the applicant is to return to active duty.
9. The following documents constitute a complete pre-appointment file:
 - a. Assignment Data Form, CG-3698A.
 - b. Four recent photographs: two full figure (front and side view) and two facial (full face and profile).
 - c. Report of Medical Examination SF-88, and Report of Medical History SF-93, each with signatures of medical and dental officers.
 - d. National Agency Questionnaire, DD Form 398-2, (for NAC only).
 - e. Police Record Check, DD-369, for the period since discharge.

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- f. Copy of separation orders and-DD-214.
- g. Personal Security Questionnaire, DD Form 398 (only if BI required).
- h. Fingerprint Cards, FD-258.
- i. Security Clearance/Determination Request and Authorization (OPNAV Form

10. On receiving the Notice of Intent copy from the applicant and an acknowledgment from CGPC-CGRC that: a National Agency Check has been initiated, CGPC-CGRC will obtain the authorization for appointment to the former grade.

11. The person will be appointed to the same grade last held on active duty as follows:

- a. Such person shall be credited at the time of subsequent appointment with any active duty commissioned service in grade he or she performed in the Coast Guard before subsequent appointment to the same grade.
- b. Such person who is receiving a subsequent appointment shall receive a new date of rank based on constructive credit for active duty commissioned service previously served in that grade in the Coast Guard.
- c. In determining a member's service time for computing time in grade under this section, each year, month and day is counted. Computations are based on the methods prescribed in the Personnel and Pay Procedures Manual, PPCINST M1000.2 (series).
- d. The constructive service credited an officer under this Article shall be used only to determine the officer's new date of rank.
- e. Once the new date of rank is established, seniority within that date of rank will be administratively determined by Commander, (CGPC-opm). In instances where the adjusted date of rank is not unique for officers in that grade, the returning officer will be given the higher precedence.

12. The pay and allowances date will be the date the applicant executes the Acceptance and Oath of Office.

13. On receiving the applicant's Notice of Intent (copy) and CGPC-CGRC's acknowledgment that a National Agency Check has been initiated, CGPC-opm-2 will determine the applicant's duty assignment and issue his or her orders at least 90 days before the appointment date. The officer will be ordered to active duty in the Coast Guard on accepting the appointment.

14. Commander, (CGPC-opm) will transmit orders to the applicant with specific directions on when to execute the Acceptance and Oath of Office.

15. On appointment, the officer is subject to the same rules of conduct and performance of duty as are all other Coast Guard officers.

16. Sample Adjusted Dates of Rank for Commissioned Officer:

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a. Promotion History

MAY 21 ENS
NOV 21 LT
NOV 21 LT (YG-86)

SNO was approved for separation on 91 OCT 31.
TIG as LT at time of separation 11 months, 11 days.
SNO was approved for return on 92 DEC 91.

91 10 31 (departure date)
90 11 21 (date of rank)
00 11 10

DEPARTURE TIG AS LT 00 11 11
Return LT DOR 92 12 01 (return date)
(adjusted) 00 11 11 (departure TIG)
00 20 (converts to 12/20/91)

New DOR is 12/20/91 (YG-87)

b. Promotion History

76 JUN 03 ENS
78 MAR 03 LTJG
81 MAY 01 LT
88 JUL 01 LCDR (YG-76)

SNO was approved for separation on 92 JUL 01.
TIG as LCDR at time of departure is 4 years, 1 day.
SNO was approved for return on 93 NOV 01.

92 07 01 (departure date)
88 07 01 (date of rank)
04 00 00
+1

DEPARTURE TIG AS LCDR 04 00 01.

Return LCDR 93 11 01 (return date)
(adjusted) 04 00 01 (departure date)
89 11 00 (converts to 10/31/89)

New DOR is 10/31/89 (YG-78).

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17. Sample Date of Rank for Chief Warrant Officer:

Promotion History (Example 1):

90 JUN 01	W-2
93 JUN 01	W-3

SNO was approved for separation on 91 SEP 01.
TIG as W-3 at time of departure: 3 months, 1 day.
TIG as W-2 at time of departure: 1 year, 3 months, 1 day.

SNO was approved for return on 93 JUN 01.

Departure W-3 TIG	91 09 01	(departure date)
	<u>91 06 01</u>	(date of rank)
	00 03 00	
	+1	
	00 03 01	

Departure W-2 TIG	91 09 01	(departure date)
	<u>90 06 01</u>	
	01 03 00	
	+1	
	01 03 01	

New W-3 DOR (adjusted)	93 06 01	(return date)
	<u>00 03 01</u>	(departure TIG)
	93 03 00	(converts to 03/01/93)

New W-2 DOR (adjusted)	93 06 01	(return date)
	<u>01 03 00</u>	(departure TIG)
	92 03 01	

b. Promotion History (Example 2):

91 JUN 01 W-2

SNO was approved for separation on 91 SEP 01.

TIG as W-2 at time of departure: 3 months, 1 day.

SNO was approved for return on 93 SEP 01.

Departure W-2 TIG	91 09 01	(departure date)
	<u>91 06 01</u>	(date of rank)
	03 00	
	+1	
	91 03 01	

New W-2 DOR (adjusted)	93 09 01	(return date)
	<u>00 03 01</u>	(departure TIG)
	93 06 00	(converts to 05/31/93)

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12.F.3.c. Service Credit for Subsequent Officer Appointment on Return to Active Duty After Separation for Care of Newborn Children

1. This provision determines a member's precedence within grade when he or she returns to active duty and receives a subsequent appointment as a commissioned, warrant, or temporary officer in a commissioned grade in the Regular Coast Guard. This provision applies to members returning to active Coast Guard duty under the CNC policy and those returning and receiving a later appointment to the Academy Permanent Commissioned Teaching Staff or designation as a Reserve Program Administrator. When subsequently appointed, the member receives credit for any active duty commissioned Coast Guard service in grade he or she performed before reappointment to the same grade.
2. The Commandant assigns a person receiving a later appointment in a commissioned grade on return to active duty a new date of rank based on credit for active duty commissioned service previously served in that grade. This procedure affords an officer credit for time previously served in grade.
3. In determining a member's service time to compute time in grade under this section, count each year, month, and day and base computations on the methods prescribed in Chapter 8, PMIS/JUMPS Manual, Volume I (Field Units), COMDTINST M1080.7 (series).
4. The previous active service credited an officer under this regulation determines his or her date of commission rank, seniority, and position on the Active Duty Promotion List.
5. Once the new date of rank is established, Commander, (CGPC-opm) administratively determines seniority within that date of rank. In cases in which the adjusted date of rank is not unique for officers in that grade, the returning officer will be given the higher precedence.

12.F.3.d. Service Credit on Reenlistment After Separation for Care of Newborn Children

1. On return to active duty, Commander, (CGPC-epm-1) credits a reenlisting member with up to one-half of the normal time in pay grade required to advance to compensate the enlisted member for time previously served in grade.
2. At a minimum, all enlisted members who separate and return under the CNC policy will be required to serve one-half the normal time required in pay grade before they are eligible to compete for advancement to the next higher pay grade.

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12.F.4. Special Terms

1. Members will separate with the understanding they will retain eligibility to return to active duty only under very specific terms. The member must submit a signed acknowledgment of the specific conditions governing separation and return to active duty with the request for separation under this policy.
2. For the purposes of this policy, a newborn is defined as a child from birth to 12 months of age (including an adopted child).
3. Members discharged from the Service are entitled to transportation of household effects from the last duty station to home or the place from which ordered to active duty.
4. On reenlistment or a new appointment under this policy, Commander, (CGPC-epm-2) or (CGPC-opm-2) generally will consider members for reassignment consistent with the needs of the Service.

12.F.5. Officer Provisions

Under this policy, officer eligibility is limited to career officers who have served on active Coast Guard duty for five years without a break in service immediately preceding the effective separation date. Commander, (CGPC-opm) generally recognizes these members as having long-term goals and aspirations in the Service because they completed an extended period of active duty or attained permanent status. They have demonstrated they possess the potential and skills for long-term active duty.

1. For the purpose of this program, career officers are defined as:
 - a. Permanent commissioned officers in the grade of lieutenant or above, or
 - b. Permanent commissioned warrant officers who have completed their three-year probationary period, or
 - c. Temporary regular officers who have completed three years of active duty commissioned service, or
 - d. Reserve Program Administrators (non-provisional) in the grade of lieutenant or above, or
 - e. Officers of the Permanent Commissioned Teaching Staff (PCTS) at the Coast Guard Academy who have completed two years' service as a PCTS member.
2. Officers submit their request to separate under this program as an unqualified resignation in the form prescribed in Article 12.A.6. with a signed Statement of Understanding for Separation for Care of Newborn Children as an attachment

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to the request. The commanding officer's endorsement shall comment on the officer's future potential and a definite recommendation for approval or disapproval.

3. Commander, (CGPC-opm-1) will discharge officers with the understanding they will return with the same grade they last held on active duty. However, the highest grade to which temporary officers will be appointed is lieutenant.
4. Officers will receive a subsequent appointment under the procedures outlined in Figure 12.F.3.2.

12.F.6. Enlisted Provisions

1. To qualify for this program, a member must be career-oriented, serving as an E-4 or above with more than four years of active duty service in the U.S. Coast Guard.
2. Enlisted members shall submit their written request for discharge under the CNC program to Commander, (CGPC-epm-1) through their commanding officer with the signed acknowledgment of conditions as an attachment to the request.
3. In the forwarding endorsement, commanding officers shall include a statement about the status of any disciplinary action pending, Service schools attended, and a definite recommendation for approval or disapproval. Enclose a copy of the Marks sheet, CG-3306, for at least four years of marks. For the 12 months before the submission of the request, the member must have an average of four in all evaluation factors and no unsatisfactory mark in Conduct. For members who have no evaluations during the 12 months preceding the request, use marks for the preceding 24 months before submitting the request.
4. Members are separated from the Coast Guard for the Convenience of the Government and receive an RE-3 reenlistment code with a letter designation that signifies the reason for separation was to care for a newborn child.
5. Any unearned Selective Reenlistment Bonus will be recouped before members separate. The remaining unearned balance will be suspended until members return to active duty. Bonus payments will resume only if members re-enlist for a period equal to or exceeding the time remaining on their commitment before they separated under the CNC policy. Bonuses will be paid in equal installments based on the number of years the members subsequently re-enlist.

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6. The member has up to two years from the separation date to re-enlist through a recruiting office and retain the previously held pay grade. Applicants are guaranteed their current pay grade if they re-enlist up to 24 months after separation. Reenlistment after this deadline is not guaranteed and will not carry the guaranteed pay grade option. Any applicant who desires to re-enlist outside the specified time frame will be subject to the limitations of the Open Rate List.
7. For advancement purposes, enlisted members' pay grade begins on their reenlistment date. **Members who return to active duty from the CNC program will receive full credit for any TIR formerly creditable prior to their separation under the CNC program. However, to be eligible to participate in SWE competition, they must serve half the minimum TIR required for advancement after returning to active duty.** **Article 5.C.14.b.**

12.F.7. Statement of Understanding

A Statement of Understanding must accompany each request for separation under the CNC policy. **Figure 12.F.7.1.**

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Figure 12.F.7.1.

STATEMENT OF UNDERSTANDING OF CONDITIONS FOR SEPARATION FOR CARE OF NEWBORN CHILDREN (CNC)

I, [member's name], acknowledge I am fully aware of the conditions for separation and re-entry in the Coast Guard under the CNC policy. I understand my discharge from the Coast Guard and return to active duty will be effected only under specific provisions stated in the CG Personnel Manual, COMDTINST M1000.6 (series). Additional CNC policy specific conditions include:

1. The member must be discharged from the U.S. Coast Guard; officers returning to active duty receive a subsequent appointment to their former grade and an adjusted date of rank; enlisted members must reenlist through a recruiting office to return to active duty with the same grade last held on active duty; an enlisted member receives a credit of up to one half the time in pay grade required to advance if he or she served such time before discharge.
2. The member must complete a physical examination at a U.S. Military Entrance Processing Station (MEPS) and meet initial entry physical standards. Waivers will be considered for conditions that existed when separated that are not disqualifying under retention standards and do not prohibit worldwide assignment.
3. After discharge, the applicant must submit a Notice of Intent to Commander, (CGPC-CGRC) with copy to Commander, (CGPC-epm) or (CGPC-opm) no less than six months and no more than one year before the intended date of return to active duty.
4. If an applicant elects to join the Coast Guard Reserve, he or she is **not guaranteed** a return to active duty as a Reservist under the CNC policy.
5. The effective separation date under the policy is within 12 months after the birth of a newborn child. Using sick leave or annual leave before or after birth does not preclude eligibility for separation under the CNC policy.
6. The member understands on discharge under this policy, he or she loses eligibility for certain benefits, among them included:
 - a. Pay and allowances;
 - b. Continued accrual of service for retirement;
 - c. Eligibility for commissary, exchange, theater, and
 - d. The member's and dependents' related privileges and medical care.

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7. The member has up to two years from the date of discharge, unless otherwise specified, to return to active duty under the CNC policy and retain the last held pay grade.
8. Members discharged from the Service are allowed transportation of household effects from the last duty station to home or the place from which they were ordered to active duty.
9. For officers, CWO (COMMS) and enlisted members in ratings requiring security clearances, this statement:

I understand in conjunction with my return to active duty, a Background Investigation or National Agency Check, as applicable, will be conducted to determine my qualifications to serve as an officer or in a specialty or rating in the USCG. If it is determined I am not eligible for a security clearance, I may lose all guarantees under the CNC policy and be separated from the Coast Guard.

Member's Signature

Date

Appendix C

Unplanned Pregnancy Prevention Program (UPPP)

**Madigan Army Medical Center
Tacoma, WA**

Unintended Pregnancy Prevention Program
Madigan Army Medical Center
Tacoma, WA 98431

Congratulations on your decision to implement the Unintended Pregnancy Prevention Program (UPPP) at your installation!

Enclosed is everything you will need to get started.

This program was designed to decrease unintended pregnancy in female soldiers, but can easily be adapted to male soldiers, other DoD service members and spouses of service members.

It is highly advised that you brief the command group at your installation before attempting to implement the UPPP. It is important to have their support before taking soldiers out of their place of duty for up to three hours for the UPPP class. Once commanders understand the potential benefit to soldier welfare and military readiness of this program, I doubt you will have difficulty gaining their support.

After you have the post/base command group's approval, I also recommend you brief the command group of each unit to be involved in the program. Your facilitators' guide contains a sample outline for a command briefing. The 10-15 minutes you spend visiting the units you recruit are valuable to the program's success. When the command is ambivalent about the program, class attendance suffers. However, when unit commanders show enthusiasm for the program and encourage all members to take part, participation nears 100%. In our experience on Fort Lewis, most commanders make the program mandatory to all members of the unit when they learn that the post commander has given the program his approval.

Some soldiers will ask commanders to excuse them from participation, especially if they have completed their child-rearing years. I recommend that commanders encourage ALL service members to participate, even if those not at risk for an unintended pregnancy. Older, more experienced participants enhance the classroom experience. They have wisdom to impart to the group. They also gain accurate information to pass on to junior members of the unit.

You are encouraged to offer all female participants the opportunity to see a health care provider within two weeks of the class. Prevention programs which incorporate BOTH health education and facilitated access to care have better success in decreasing unintended pregnancy rates than those which do not. In our experience, about 15% of participants take us up on the offer of a clinic visit.

In addition to the sample commanders' briefing, your materials include an educational videotape and accompanying facilitators' guide. Also included are copies of pre and post-tests, a worksheet and an evaluation form to be administered to program participants. All materials are on the enclosed floppy disc; feel free to modify to your needs.

Periodically, we will offer one-day training seminars at Fort Lewis, WA for those who wish to observe a class and to consult with program coordinators. Please inform me if you are interested in attending a training seminar.

I will contact you in several weeks to discuss your experience with the UPPP. Please contact me anytime if you have questions.

Diane M. Flynn, LTC, MC

email:Ltc_Diane_Flynn@smtplink.mamc.amedd.army.mil

UNINTENDED PREGNANCY PREVENTION PROGRAM

Command Briefing

Purpose

Present an overview of the
Unintended Pregnancy Prevention
Program

- Decrease Unplanned Pregnancy
- Enhance Female Soldier Readiness

Background

Pregnancy rate at Fort Lewis:

*16 pregnancies / 100 women / year

*includes positive HCG tests at MAMC
or women who delivered at MAMC

Problem

Of 344 female soldiers beginning prenatal care at MAMC:

<u>RANK</u>	<u>#</u>	<u>% UP</u>	<u>% UP not using BC</u>
E1-E2	49	82%	57%
E3-E4	211	56%	65%
E5-E9	49	35%	41%
<u>O1-O4</u>	<u>35</u>	<u>40%</u>	<u>71%</u>
TOTAL	344	55%	62%

UP=unintended pregnancy BC=birth control

Cost to the Unit of a Soldier with an Unintended Pregnancy

At a minimum:

- ◆ 9 months nondeployable and modified duty.
- ◆ 12 doctor visits during pregnancy.
- ◆ 6 weeks convalescent leave.

Focus Groups Revealed

- ◆ Education is needed and wanted by female soldiers.
- ◆ Given the opportunity, many would begin or change birth control method.
- ◆ Female soldiers preferred that classes be restricted to women.
- ◆ There are perceived barriers to health care.

Educational Intervention

- ◆ 3 hour interactive class at the unit. Class may be restricted to women, to men or may be mixed gender.
- ◆ Review of family planning attitudes, reproductive cycle, contraceptive options, responsible decision making.

Educational Intervention (cont)

- ◆ CLASS OBJECTIVE: Soldiers will take control of their reproductive lives and realize that there is a safe and effective method of birth control for each individual.

Facilitated Access to Health Care

After each class, female participants may sign up for a block of appointments set aside for their unit in the GYN clinic.

Summary

The Unintended Pregnancy Prevention Program:

- Will enhance understanding of reproductive issues among soldiers
- Will enhance access to contraceptive services
- Will reduce unintended pregnancy
 - » improve quality of life
 - » promote readiness

To schedule a class:

Name a POC here.

Questions?

UNINTENDED PREGNANCY PREVENTION PROGRAM

MADIGAN ARMY MEDICAL CENTER
TACOMA, WA

Additional copies available through the
UNINTENDED PREGNANCY PREVENTION PROGRAM
253/968-2067 (DSN 782)
FAX: 253/968-2608
email: Ltc_Diane_Flynn@smtplink.mamc.amedd.army.mil

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CPT Jennifer Potter, DO

Family Practice

Cynthia Toft, RNC

Nursing Education

Unintended Pregnancy Prevention Project
Educational Intervention

FACILITATOR'S GUIDE

Note to facilitators: Suggested script for presentation to class are given in *italics*. Non-italicized text is supplemental information for your reference only.

I. Introduction:

My name is _____ and I (describe your position). I am here with you today to discuss unplanned pregnancy – some of reasons unplanned pregnancies occur and some strategies to postpone pregnancy until a couple decides that's what they want. This class will last about 2 ½ - 3 hours and we'll have a couple of breaks during that time.

A. Pretest. Distribute pretests and worksheets.

Please complete the brief pretest being distributed: It will help us to determine what you already know. There is no need to put your name on the test. The correct answers will be discussed at the end of today's exercise.

Pretest:

1. In a woman with regular monthly menstrual cycles, she is MOST LIKELY to get pregnant is:
 - a) during her period
 - b) a few days after her period ends.
 - c) about a week and a half after her period ends.
 - d) a few days before her next period starts.

2. Out of 100 typical women who use the injectable contraceptive Depo Provera, how many will get pregnant within one year of use?
 - a) less than 5 out of 100
 - b) between 5 to 20 women out of 100
 - c) between 21 to 50 women out of 100
 - d) more than 50 women out of 100.

3. Out of 100 typical couples who use condoms (alone without spermicide), how many will have pregnancy occur within one year?

- a) less than 5 out of 100
- b) between 5 to 20 couples out of 100
- c) between 21 to 50 couples out of 100.
- d) more than 50 couples out of 100.

4. Which of the following methods of birth control offers the **best** protection against sexually transmitted diseases?

- a) the birth control pill
- b) the contraceptive shot (Depo Provera)
- c) the implantable contraceptive (Norplant)
- d) the condom

5. What is the effect of taking the birth control pill on a woman's risk of cancer of the ovary?

- a) taking the pill increases a woman's risk of ovarian cancer.
- b) taking the pill does not effect a woman's risk of ovarian cancer.
- c) taking the pill decreases a woman's risk of ovarian cancer.

Allow majority of participants to complete pretest (about 3-5 minutes).
Collect pretests.

B. Reproductive Life Plan. *Please take five minutes to consider and answer questions 1-6 on the first page of your worksheets. We will not discuss your answers as a group, but you may wish to consider your responses as we complete the rest of today's exercise. Some of the questions will not apply to those of you who do not plan to have children in the future. Please disregard those questions.*

1. How old do I want to be when my first (or next) child is born?
2. How old do I want to be when my last child is born?
3. How many children do I want to have?
4. How do I picture my life when my first (or next) child is born?
Are there educational, training or financial goals I want to accomplish first?
5. If I did not want to have a baby, how would I handle an unplanned pregnancy?
6. How would I feel if I were unable to have children?

After about 5 minutes, continue with the videotape

II. Overview of Class / Review of statistics on Unintended Pregnancy.

Let's start with a brief videotape which will review the topics we will discuss today.

START TAPE.

- A. Class Outline
- B. Reproductive Risk Taking

TURN TAPE OFF WHEN INSTRUCTED.

After first portion of the videotape, ask for and address any questions or comments. Then ask:

Why do you think some couples risk pregnancy when safe and effective birth control is available?

Facilitate a discussion of responses. The idea here is to generate ideas and encourage participation. By not judging or evaluating responses, you will give the message that the group is a safe place to voice opinion.

At this point keep the discussion non-personal, "Why do couples take risks" not "Why do you take risks". If women give personal examples, that's ok; it shows they feel safe in the group, but gently bring the discussion back to the non-personal. For example, "OK, what are other reasons couples sometimes take risks". If group participation is minimal, you may want to bring up some of the following reasons and ask the group if they might lead to risk taking in some couples: "sex should be spontaneous",

- "some partners will not consistently support condom/diaphragm use",
- "couples get caught up in the heat of the moment",
- "alcohol clouds their judgment",
- "abortion is available",
- "some couples have a poor understanding of the menstrual cycle and how it relates to fertility".

You may want to ask:

What information do women and their male sexual partners need and what can they do to decrease the risk of an unplanned pregnancy?

III. Menstrual Cycle

START TAPE.

Overview of Menstrual Cycle

STOP TAPE WHEN INSTRUCTED.

Diagram of the menstrual cycle – group exercise. Divide group into approximately four groups of 5 – 10 individuals each. Distribute a piece of butcher block paper to each group along with some colored markers or crayons.

Please work together in your small groups for 10 minutes to draw a diagram representing a woman's menstrual cycle. Include the time of the menstrual period, the time of ovulation (release of the egg), as well as the time when a woman is most likely and least likely to get pregnant. Have fun and be creative. Pretend you are trying to explain the menstrual cycle to a friend.

After about 10 minutes, ask each group to present their diagram to the class. Ask the class to comment on each. If information is wrong, point out the inaccuracies without putting anyone on the spot. You may want to sandwich a correction between two positive statements, e.g., "You very clearly show the time of a woman's period, but the time of the cycle when a woman is most likely to get pregnant is usually several days later than your diagram shows, usually about 14 days before the next period starts. I like the way you clearly indicate the changes in the vaginal discharge that occur when a woman is most fertile."

--- 10 MINUTE BREAK ---

IV. CONTRACEPTIVE METHODS

A. Personal Challenges

On your worksheets, list 3-5 obstacles to consistent and correct use of birth control you have experienced in previous or current relationships. Again, your responses are personal and will not be discussed with the group.

Allow 5 minutes for this exercise. No need to discuss responses.

START TAPE.

Overview of contraceptive options

TURN TAPE OFF WHEN INSTRUCTED.

After video:

Any questions?

B. Reasons pregnancy would/would not be good now.

On your worksheets, take 5 minutes and list 2-3 reasons why would be a good time for you to get pregnant and 2-3 reasons why now would be a bad time to get pregnant.

After a few minutes, encourage group to discuss some of their answers. If they seem unwilling to discuss this with the group, don't push it. If you do get some response, you may want to point out the difference between the logical and emotional responses.

--- 10 MINUTE BREAK (optional) ---

For the remainder of the class, we will discuss the importance of prevention of sexually transmitted diseases, then discuss choices of birth control for men and women in different situations.

START TAPE.

V. SEXUALLY TRANSMITTED DISEASES

VI. CONTRACEPTIVE CHOICES

Assign discussion of one of the following scenarios to each small group. After about 10 minutes, facilitate group discussion of each scenario, using above points for discussion as needed, after each small group presents their conclusions.

Scenario 1

- a. Carol does not want to start a family for a few years and has been taking the birth control pill for several months. She has had no side effects, but she often forgets to take the pill, and misses about five pills per month. She knows that the pill is much less effective at preventing pregnancy when pills are missed so she is thinking about changing her birth control method. What are some good options for Carol? Why? If Carol is not in a stable, committed relationship, what else does she need to consider in order to protect her fertility? What could Carol do to prevent pregnancy if she had sex last night after missing four birth control pills in a row?

Points for discussion... Good choices for Carol include the contraceptive shot (e.g. Depo Provera), contraceptive implant (e.g. Norplant), condoms if she is sure she and her partner/husband will use consistently, particularly if she is at risk for STDs. Another good choice is continuing the pill and using some memory cues to help her to remember to take it consistently, such as placing the pills next to her toothbrush. If she had unprotected sex last night, she can take emergency contraception as directed to prevent pregnancy.

Scenario 2

- b. Susan is not currently in a relationship. When she is attracted to a man and he shows an interest, she may have sex with him, even if she does not know him well. She has been relying on condoms with contraceptive foam for birth control, but sometimes gets carried away when she is intimate with a man and forgets to use the condoms,

especially when she has had a few drinks. Susan knows if something doesn't change, she is very likely to end up pregnant or infected with an STD. What are some good choices of birth control for Susan? How can Susan protect herself from STDs?

Points for discussion...Birth control pills would be a good choice (only if she will remember to take them regularly). Others include injectable or implantable contraceptive, and avoiding alcohol in situations in which she is likely to have sex. Reinforce the importance of condoms when at risk for STDs. Susan should use condoms plus another more effective method of contraception to protect herself against unplanned pregnancy and STDs. Reinforce the danger of alcohol when it leads to women making decisions that expose them to risks. The IUD is not a good choice for Carol due to the increased risk of pelvic infections in women with multiple sex partners; some pelvic infections can lead to infertility.

Scenario 3

c. Philip and his girlfriend have been using the withdrawal ("pulling out") method of birth control. They try to be especially careful with birth control about two weeks before she expects her next period because she knows that is when she is most likely to get pregnant. However, Philip knows the withdrawal method has a fairly high failure rate in typical couples who use it. He suggested to his partner that she consider going on the pill, but she is a little worried about starting this method because friends have told her that the pill causes a lot of side effects and is bad for a woman's health. What would you advise Philip to do? What are some good birth control choices for Philip and his partner? What does Philip need to consider besides preventing pregnancy?

Points for discussion...Philip should tell his girlfriend that most women who take the pill tolerate it well. They may experience nausea, breast tenderness or a gain a few pounds in the first few months, but these symptoms usually subside within a few cycles. In women who do experience side effects, changing to another type of pill will often control the side effects. The birth control pill has several health benefits such as causing lighter and less painful periods in many women, decreased risk of uterine and ovarian cancer and pelvic infections. Other feasible choices include the injectable or implantable contraceptive, condoms with contraceptive gel, foam or film. Philip should also consider using condoms to protect himself from STDs.

Scenario 4

d. Julie is a single soldier who is happy with her current method of birth control, the birth control pill. However, her unit is being deployed to the Middle East for an uncertain number of months. She does not know if she will be sexually active while in the Middle East and does not know much about the hygiene facilities there. What methods of birth control would you advise Julie to consider? What does Julie need to consider in choosing a birth control method that will work for her and protect her from STDs?

Points for discussion...First, advise Julie to find out which methods of birth control will be available to her while deployed. She could make the decision to remain abstinent while in deployed. Or she could continue OCPs. If she is uncertain if OCPs will be available, the pharmacy will usually give more than the usual 3 month supply if she shows them a copy of her orders. The contraceptive shot (e.g. Depo Provera) is another option. Mention that over half of women who use this method for more than 6-9 months stop having periods altogether, a significant advantage in the field since it means no periods, tampons or pads to worry about. The implantable contraceptive which may not be available at all military posts is another good method, especially if Julie wants to postpone childbearing for several years.

TURN TAPE OFF WHEN INSTRUCTED AND COMPLETE SMALL GROUP EXERCISE. AFTER DISCUSSION OF SCENARIOS, CONTINUE WITH FOLLOWING:

VII. Bringing it all together

A. Contraceptive Choices

There are several safe and effective methods of birth control available today. Considering all we have discussed today, and considering your own personality, relationships, religious background and future child bearing desires, list on your worksheets the 2-3 worst methods of birth control and 2-3 of the best methods of birth control FOR YOU.

Allow a few minutes for this exercise.

B. Posttest

Please take a few moments to complete this brief test. Your answers will help us to determine if we have helped to you to discover anything new. I will tell you the correct answers as a group when you finish.

1. During the time when a woman is MOST LIKELY to get pregnant, her vaginal discharge normally:
 - a. decreases in amount and is thick and tacky, like school paste.
 - b. increases in amount and is clear and slippery, like raw egg-whites.
 - c. increases in amount and has a fishy odor.
 - d. is bloody.

2. Out of 100 typical women who use the birth control pill for contraception, how many will get pregnant within one year of use?
 - a. less than 5 women out of 100
 - b. between 5 to 20 women out of 100
 - c. between 21 to 50 women out of 100
 - d. more than 50 women out of 100

3. Out of 100 typical sexually active women who use no birth control, approximately how many will get pregnant within one year?
 - a. 20 out of 100 women.
 - b. 35 out of 100 women.
 - c. 60 out of 100 women.
 - d. 85 out of 100 women.

4. How does taking the birth control pill affect a women's risk of pelvic bacterial infections?
 - a. Taking the pill increases a woman's risk of pelvic infections.
 - b. Taking the pill has no effect on a woman's risk of pelvic infections.
 - c. Taking the pill decreases a woman's risk of pelvic infections.

5. How does using the contraceptive shot (Depo Provera) effect a woman's risk of cancer of the uterus (womb)?

- Using the injectable contraceptive increases a woman's risk of uterine cancer.
- Using the injectable contraceptive has no effect on a woman's risk of uterine cancer.
- Using the injectable contraceptive decreases a woman's risk of uterine cancer.

Collect tests when majority of class are finished.

START TAPE.

ANSWERS TO PRE AND POST-TESTS

TURN TAPE OFF WHEN COMPLETED.

VIII. CONCLUSION

We have covered a lot of material today. You have thought about your plans and desires for having children in the future. You learned about the high rate of unintended pregnancy in female soldiers. You explored why some women take reproductive risks. You reviewed the menstrual cycle and the methods of birth control available today. We discussed emergency birth control a woman can use within 72 hours of intercourse if her method of birth control fails, for whatever reason. We briefly talked about STDs and how they can impair a woman's fertility. You thought about some of the reasons why now would or would not be a good time for you to get pregnant. And you reached some decisions on the best methods of birth control FOR YOU.

If you decided that the best method of birth control FOR YOU is something different from what you are currently using, ask yourself, "what do I need to do to begin the method that is best for me?"

Distribute evaluations.

Please take a few minutes to complete the evaluation form I am distributing you. They will help us to know how we can make this program better.

Any of you who are interested in going to the OB/GYN clinic during the next 2 weeks to get more information on anything we discussed or to get a prescription for a birth control method, please complete the appointment slip at the bottom of the evaluation form. Your unit has already approved your absence to go to the clinic if you wish.

Inform women who sign up that they must bring their records to the appointment. Woman who are menstruating at the time of their appointment may still keep the appointment, but they may be advised to reschedule a pap smear if one is indicated. If the woman has her period on the day of her appointment, and prefers not to have a GYN exam during her menses, she can reschedule the appointment for another time.

Unintended Pregnancy Prevention Program

Worksheet

When instructed, please answer the questions on this page. Consider your responses to these questions throughout the rest of today's exercise. Your answers are personal and will not be discussed with the class.

1. How old do I want to be when my first (or next) child is born?

2. How old do I want to be when my last child is born?

3. How many children do I want to have?

4. How do I picture my life when my first (or next) child is born? For example, will I be in the Army? Will I be married? Will I own my own home? Will I have completed my educational or vocational training goals?

When instructed please take about five minutes to answer question 8. Your responses are personal and will not be discussed with the class.

7. Factors that have made it difficult for me to use birth control correctly and consistently include:

- a) _____
- b) _____
- c) _____
- d) _____
- e) _____

When instructed, take about 5 minutes to list 2 or 3 responses for questions 9 and 10. Your responses are personal and will not be discussed with the class.

8. Now would be a GOOD time for me to get pregnant or for me to father a pregnancy because:

- a) _____

- b) _____

- c) _____

9. Now would be a BAD time for me to get pregnant or father a pregnancy because:

- a) _____

- b) _____

- c) _____

10. Your small group will be asked to consider one of the four imaginary women presented below. Please answer the questions on the space provided. You will have about 10 minutes for this exercise.

a) Carol does not want to start a family for a few years and has been taking the birth control pill for several months. She has had no side effects, but she often forgets to take the pill and misses an average of five pills per month. She knows that the pill is much less effective at preventing pregnancy when pills are missed so she is thinking about changing birth control method.

What are some good birth control options for Carol? Why? If Carol is not in a stable, committed relationship, what else does she need to consider in order to protect her fertility? What could she do to prevent pregnancy if she had sex last night after missing four birth control pills in a row?

b) Susan is not currently in a relationship. When she is attracted to a man and he shows an interest in her, she may have sex with him, even if she does not know him well. She has been relying on condoms and contraceptive foam for birth control. However, she sometimes gets carried away when she is intimate with a man and forgets to use the condoms, especially if she has had a few drinks. Susan knows if something does not change, she is likely to end up pregnant or infected with an STD.

What are some good choices of birth control for Susan? How can Susan protect herself from STDs?

c) Philip and his partner have been using the withdrawal ("pulling out") method of birth control. They try to be especially careful with birth control about two weeks before she expects her next period because she knows that is when she is most likely to get pregnant. However, Philip knows the withdrawal method has a fairly high failure rate in typical couples who use it. He suggested to his partner that she consider going on the pill, but she is a little worried about starting this method because friends have told her that the pill causes a lot of side effects and is bad for a woman's health.

What would you advise Philip to do? What are some good birth control choices for Philip and his partner? What else does Philip need to consider besides preventing pregnancy?

d) Julie is a single soldier who is happy with her current method of birth control: the birth control pill. However, her unit is being deployed to the Middle East for an uncertain number of months. She does not know if she will be sexually active while in the Middle East and she does not know much about the hygiene facilities there.

What does Julie need to consider in choosing a birth control method that will work for her and protect her and protect her from STDs?

Consider everything we talked about today to answer the following questions.

11. The worst methods of birth control FOR ME are:

12. The best methods of birth control FOR ME are:

Evaluation

1. What did you learn today that you never knew before?

2. What would you change about today's exercise to make it better?

3. What, if anything, will you do differently as a result of today's exercise?

TEAR ALONG LINE IF YOU PREFER YOUR EVALUATION TO BE ANONYMOUS

.....

OB/GYN appointment:

If you want to start a new method of birth control, you may sign up for one of the following dates for an OB/GYN Clinic appointment. Please give this slip to the class leader.

I will go to the OB/GYN Clinic at 0800 on _____ / _____ (circle one)

Your Name _____

TEST A

Circle the correct response.

1. In a woman with regular monthly menstrual cycles, she is **MOST LIKELY** to get pregnant:
 - a. during her period.
 - b. a few days after her period ends.
 - c. about a week and a half after her period ends.
 - d. a few days before her period starts.

2. Out of 100 typical women who use the injectable contraceptive (Depo Provera), how many will get pregnant within one year of use?
 - a. less than 5 women out of 100
 - b. between 5 to 20 women out of 100
 - c. between 21 to 50 women out of 100
 - d. more than 50 women out of 100

3. Out of 100 typical couples who use condoms alone for birth control, how many women will get pregnant within one year of use?
 - a. less than 5 women out of 100
 - b. between 5 and 20 women out of 100
 - c. between 21 and 50 women out of 100
 - d. more than 50 women

4. Which of the following methods of birth control offers the best protection against sexually transmitted diseases?
 - a. the birth control pill
 - b. the contraceptive shot (Depo Provera)
 - c. the implantable contraceptive (Norplant)
 - d. the condom

5. What is the effect of taking the birth control pill on a woman's risk of cancer of the ovary?
 - a. taking the pill increases a woman's risk of ovarian cancer.
 - b. taking the pill does not effect a woman's risk of ovarian cancer.
 - c. taking the pill decreases a woman's risk of ovarian cancer.

TEST B

Circle the correct answer

1. During the time when a woman is **MOST LIKELY** to get pregnant, her vaginal discharge normally:
 - a. decreases in amount and is thick and tacky, like school paste.
 - b. increases in amount and is clear and slippery, like raw egg-whites.
 - c. increases in amount and has a fishy odor.
 - d. is bloody.

2. Out of 100 typical women who use the birth control pill for contraception, how many will get pregnant within one year of use?
 - a. less than 5 women out of 100
 - b. between 5 to 20 women out of 100
 - c. between 21 to 50 women out of 100
 - d. more than 50 women out of 100

3. Out of 100 typical sexually active women who **use no birth control**, approximately how many will get pregnant within one year?
 - a. 20 out of 100 women.
 - b. 35 out of 100 women.
 - c. 60 out of 100 women.
 - d. 85 out of 100 women.

4. How does taking the birth control pill affect a woman's risk of pelvic bacterial infections?
 - a. Taking the pill **increases** a woman's risk of pelvic infections.
 - b. Taking the pill **has no effect** on a woman's risk of pelvic infections.
 - c. Taking the pill **decreases** a woman's risk of pelvic infections.

5. How does using the contraceptive shot (Depo Provera) effect a woman's risk of cancer of the uterus (womb)?
 - a. Using the injectable contraceptive **increases** a woman's risk of uterine cancer.
 - b. Using the injectable contraceptive **has no effect** on a woman's risk of uterine cancer.
 - c. Using the injectable contraceptive **decreases** a woman's risk of uterine cancer.

Abstinence (Not having sexual intercourse)

WHAT IS ABSTINENCE?

Abstinence means different things to different people. It depends on how those two people are interacting sexually. For a man and a woman, if one is thinking about sexual activity which can lead to pregnancy then abstinence refers to penis-in-vagina intercourse. For two men abstinence means other things. For two women it means still other things. While abstinence means many different things, on this page it refers to not having sexual intercourse - the penis is not going into the vagina. Some people will use other kinds of touching to satisfy their needs. Others will avoid any kind of touching because it is too tempting. Some people have intercourse once, several times or many times and then later on change their minds and decide they would like to return to abstinence for a period of time in their lives. Some people use abstinence just for tonight. As in "lets not have sex tonight."

ADVANTAGES:

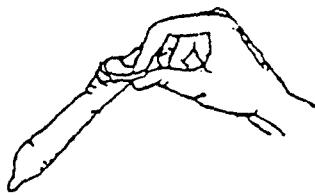
- *Abstinence is free and available to all.
- *Abstinence extremely effective at preventing infection and pregnancy.
- *Abstinence can be started at any time in your life.
- *Using abstinence can help people learn other ways of building their relationship.
- *Abstinence may be the course of action which you feel is right for you and makes you feel good about yourself.

DISADVANTAGES:

- *If you're counting on abstinence, and change your mind in the heat of the moment, you might not have birth control handy. People who want to use abstinence really differ as to how they approach the *possibility* that they *might* have intercourse.
- Some people would rather be prepared* and have a condom available in case they change their mind. *Some people feel that having a contraceptive ready and available might tempt them.*

CONDOMS WORK!!!

The more you use them,
the safer you will be.



WHAT are condoms? Condoms look like long thin balloons (before they are blown up). Condoms are made of latex (often called "rubbers"). Also made of polyurethane, or natural membranes. They prevent body fluids from mixing when two people have sex.

ADVANTAGES: * Safe and effective at preventing both pregnancy and infection

- * The best method of preventing infection if two people are going to have sex
- * Men "last longer" sometimes making sex more fun for him and for her.
- * Condoms come in many colors, sizes and with or without ribbing. Variety is exciting!
- * Condoms prevent the messy discharge women get when the man comes into the vagina
- * If the woman puts the condom on for the man, it can be fun for both him and her!
- * Remember! Penises and condoms come in different sizes! So find a condom that fits!
- * If you a water based lubricant such as Astroglide, KY Jelly or KY Jelly Plus Nonoxynol-9, it may decrease the chance of your condom breaking.
- * To decrease the chance of the condom slipping down the penis or falling off in the vagina, pull the penis out of the vagina right after ejaculation. Don't continue thrusting until the penis becomes soft. Hold the rim of the condom onto the shaft of the penis during withdrawal.
- * Practice putting a condom onto a banana! This will make it easier using a condom later on. Practice definitely helps when you are using condoms.

DISADVANTAGES: *Condoms interrupt sex!

- *When putting the condom on the penis you must avoid tearing the condom or putting a hole in it with finger nails, a ring or anything sharp. This includes anything in the mouth which is sharp!
- ***DO NOT USE OIL BASED LUBRICANTS**, such as Vaseline, sun tan oil, whipped cream, or Crisco! These products can cause a hole in a condom in a matter of seconds.
- *Some men cannot maintain an erection with a condom on. This is not common.
- *Some people actually use 2 condoms...particularly if either person might have an infection, a discharge, or signs of intravenous drug use such as needle marks.
- *The man must pull out soon after ejaculation. If he becomes soft, the condom can fall off.
- *Some men are sensitive to latex.

WHERE do I get condoms! From any drugstore and many supermarkets, and gas stations. Some health departments and family planning clinics give away free condoms.

WHAT IF I HAVE SEX AND DON'T USE BIRTH CONTROL?

Did you know that.... for 72 Hours.... after sex, you can take emergency pills to avoid becoming pregnant ? AND for 5 Days....after sex, you can have an IUD put in, so you won't become pregnant. Not all doctors know about this. If you need to know more or would like the phone numbers of doctors or clinics near you that have emergency birth control,

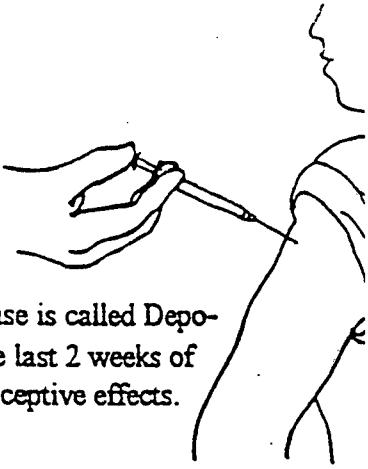
Call: (800)- 584-9911.....

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Depo-Provera Injections

"The Birth Control Shot"

But you have to return each 3 months



WHAT are birth control shots? The type of shot we currently use is called Depo-Provera. It is a hormone much like the progesterone a woman produces during the last 2 weeks of each monthly cycle. It stops the woman from passing an egg and has other contraceptive effects.

ADVANTAGES: *Nothing needs to be taken daily or at the time of sexual intercourse.

*Extremely effective. If women receive their injections right on time (every 13 weeks or 3 months), only 3 women in 1,000 become pregnant in the course of an entire year.

*Women lose less blood using Depo-Provera, have less menstrual cramps and lose less blood.

*Privacy is a major advantage. No one needs to know you are using this method.

*Nursing mothers can take progestin-only pills.

DISADVANTAGES: *Depo-Provera injections can lead to very irregular periods. If your bleeding pattern is bothersome to you, there are medications which can be given to you which may make you have a more acceptable pattern of bleeding.

*Some women gain weight. To avoid weight gain, watch your calories and get lots of exercise.

*You have to return each three months for your injection.

*Depression and premenstrual symptoms may improve or become worse.

*Depo-Provera does not protect you from AIDS or other infections. Use condoms if at risk.

*It may be a number of months before your periods return to normal after your last shot.

*Depo-Provera may cause bone loss although this is not certain. Get regular exercise and consider taking extra calcium to protect your bones from osteoporosis.

*An occasional women is allergic to Depo-Provera.



WHERE can I go to get started using Depo-Provera shots? *You can get Depo-Provera injections from your doctor, nurse practitioner, nurse midwife, health department, or Planned Parenthood clinic. Most clinics provide the first shot when a woman is on her period or within 7 days of the start of the period. If the risk of pregnancy can be excluded it may be possible to start injections at other times.

What if I have sex and I am late for my shot? If you have sex and you are late for your shot, be sure to use condoms or another method.

WHAT IF I HAVE SEX AND DON'T USE BIRTH CONTROL?

Did you know that.... for 72 Hours.... after sex, you can take emergency pills to avoid becoming pregnant ? AND for 5 Days....after sex, you can have an IUD put in, so you won't become pregnant. Not all doctors know about this. If you need to know more or would like the phone numbers of doctors or clinics near you that have emergency birth control,

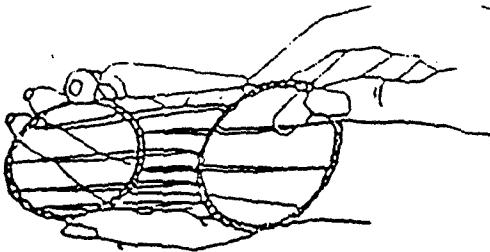
Call: (800)- 584-9911.....

Choices: DEPO-PROVERA; the birth control shot Preparation of this material was not supported by funds from a pharmaceutical company, is not copyrighted, and may be copied or adapted without asking permission. rah, cmb, kmb: 8/2/96; 404-616-3709 or 706-782-6038.

CONDOMS FOR WOMEN:

(The Reality Female Condom)

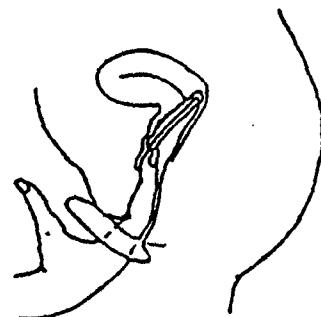
An exciting adventure into contraception!



WHAT IS the female condom? Reality female condoms are made of a thin plastic called polyurethane. This is NOT latex or rubber. The condom is placed into the woman's vagina. It is open at one end and closed at the other. Both ends have a flexible ring used to keep the condom in the vagina. The instruction pamphlet explains how to insert the condom.

ADVANTAGES: *Female condoms give women more control.

- *You don't need to see a doctor to get it. No prescription or fitting needed
- *Can be put in several hours in advance of sexual intimacy
- *Safe and fairly effective at preventing both pregnancy and infection
- *Any lubricant may be used with the female condom
- *Can be used by individuals who are sensitive to latex



DISADVANTAGES: *This condom is large and some call it unattractive or odd looking. "It looks like a condom for a slinky" said someone!

- *Sometimes the man places the penis outside of the Reality female condom.
- *If put in advance, it can make rustling noises! It can also make undesirable little noises during intercourse. Try using a lubricant if noises are a problem.
- *Takes practice to use it right. Some people complain it is hard to use.
- *May not be able to get them in as many stores as the male condom.

WHERE can I get Reality female condoms?

- *Sold at most drugstores and at some supermarkets. Call in advance to be sure
- *Sold in packs of three or six and costs \$2 to \$3 per condom
- *The package comes with a leaflet that explains how to use the condom
- *The Golden Rule: Only Proper Use Gives Proper Protection
- * To learn more about the Reality condom, call your doctor or call 1-800-274-6601

WHAT IF I HAVE SEX AND DON'T USE BIRTH CONTROL?

Did you know that... for 72 Hours... after sex, you can take emergency pills to avoid becoming pregnant? AND for 5 Days... after sex, you can have an IUD put in, so you won't become pregnant. Not all doctors know about this. If you need to know more or would like the phone numbers of doctors or clinics near you that have emergency birth control, Call: (800)- 584-9911.....

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EMERGENCY CONTRACEPTIVE PILLS (ECPs)

LEVLEN, TRIPHASIC | 00 00 + 0000
OR TRILEVLEN (yellow) | AS SOON AS POSSIBLE 12 HOURS LATER
OR
OVRAL (PILLS) } 00 + 00
} AS SOON AS POSSIBLE 12 HOURS LATER

Have you ever in your life:

- *Made love unexpectedly?
- *Awakened to realize you were having sex?
- *Been forced to have sex?
- *Counted on pulling out... but didn't?
- *Had a condom slip or come off?
- *Found out after sex your diaphragm had slipped?
- *Forgotten several birth control pills?
- *Been caught in the act without having your act together?

Well, if the answer is "yes" to any of the above questions, you should know about emergency contraceptive pills.

WHAT ARE emergency contraceptive pills?

- *For 72 Hours.... after unprotected intercourse, you can take emergency contraceptive pills to avoid becoming pregnant? ECPs are two large doses of birth control pills. A drug to prevent nausea is often taken too.
- *If your ECPs are Lo-Ovral, Nordette, Levlen, Tri Levlen (yellow pills) or Tri Phasil (yellow pills), you take 4 pills within 72 hours of unprotected intercourse and repeat in 12 hours.
- *If your ECPs are Ovral, you take 2 pills within 72 hours of unprotected intercourse and repeat this in 12 hours. Ovral is more expensive than other ECPs and some drugstores don't carry Ovral.

ADVANTAGES:

- *They prevent unwanted pregnancies
- *Some women can use ECPs who can't take pills on a regular basis
- *Prevent abortions and cost less than an abortion



DISADVANTAGES:

- *Nausea (about 50%) or vomiting (25%)
- *Not as effective as other contraceptives
- *Should not be used as your regular contraceptive. You may think you could use emergency contraceptive pills (ECPs) over and over again as your regular contraceptive. This is not a good idea as ECPs are not as effective as other approaches. But if you make several mistakes and use ECPs several times, they are not dangerous.
- *Must get a prescription from your doctor. Not available without a prescription.

WHERE can I get emergency contraceptive pills? You can go to your physician or family planning clinic for these services. Some physicians are not familiar with emergency contraception. In this case:

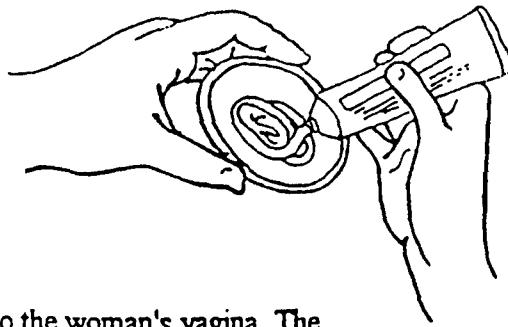
Call: (800)- 584-9911

By calling this emergency contraceptive hotline number you can get the phone numbers of 3 clinics or physicians nearest to you who will help you get emergency contraceptive pills AND information about the other two options open to women after unprotected sex.

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THE DIAPHRAGM

But it is such a long distance
from the bedroom to the bathroom!!



WHAT is a diaphragm? A rubber disc which is placed into the woman's vagina. The diaphragm blocks the man's semen from entering the cervix (the opening to the womb). A spermicide placed onto the diaphragm kills sperm. Diaphragm and the spermicide keep sperm from getting to the egg..

ADVANTAGES: *Gives a woman fairly good control over contraceptive.

- *Safe, and fairly effective at preventing pregnancy. *When used perfectly*, only 6 couples in 100 become pregnant the first year using a diaphragm.
- *Can be put in several hours in advance of sexual intimacy.
- *No hormones or side effects from hormones.
- *The penis can remain inside the female condom after ejaculation.



DISADVANTAGES: *Must be obtained through a doctor or nurse practitioner.

It is difficult for some women to insert a diaphragm properly even after being taught

- *You should wash your hands with soap and water before putting your diaphragm in

*May interrupt sex

*Have to take it with you on vacations or trips.

*Increases your risk for urinary track infections.

*Some women find the diaphragm large and unattractive.

*If left in too long, increases slightly your risk for a very serious infection called toxic shock syndrome. Don't leave your diaphragm in for more than 48 hours.



*May slip out of place during sex. If you change who is on top, you may want to check to see that the diaphragm is still covering the mouth of your womb (called the cervix).

*After putting it in you have to check to be sure it is covering the opening of the uterus which is called your cervix.

WHERE do I go to get a diaphragm? You need to be fitted in a doctor's office for a diaphragm. Be sure you are shown how to insert and remove a diaphragm. Then you are given a prescription for the specific type of diaphragm you will use. You will go to a drugstore to get the actual diaphragm and the spermicide you will use with the diaphragm.

WHAT IF I HAVE SEX AND DON'T USE BIRTH CONTROL?

Did you know that.... for 72 Hours.... after sex, you can take emergency pills to avoid becoming pregnant ? AND for 5 Days....after sex, you can have an IUD put in, so you won't become pregnant. Not all doctors know about this. If you need to know more or would like the phone numbers of doctors or clinics near you that have emergency birth control,

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Fertility Awareness Methods (FAM)

WHAT IS the fertility awareness method (FAM)? Fertility Awareness is a means of understanding your reproductive system by observing and writing down fertility signs. These signs determine whether or not you can become pregnant on a given day. You are actually fertile only about a fourth of your cycle. It is a great way to learn more about your body and can help you to understand some problems women have. What are the three primary fertility signs? They are your temperature when you first wake up; cervical fluid (the fluid at the mouth of your womb); and the position of your cervix.

BEFORE OVULATION

Waking temperatures remain low

Cervical fluid is initially dry after menstruation becomes wet and similar to raw eggwhite

Cervix rises and becomes softer and open

AFTER OVULATION:

Waking temperatures rise for 12-16 days

Cervical fluid quickly dries up after then ovulation

Cervix quickly drops and becomes firm and closed after ovulation

ADVANTAGES:

- *Intercourse without condoms, chemicals or hormones.
- *Helps you track and improve PMS (premenstrual syndrome) symptoms
- *Empowers you with practical knowledge, leading to increased self-esteem.
- *Helps you become pregnant as well as to avoid pregnancy.

DISADVANTAGES:

- *Involves daily charting of fertility signs
- *Requires discipline for a number of days in the cycle if you choose to avoid sex rather than use a barrier contraceptive during your fertile days.
- *You can only use this if both you and your partner have only one partner and have no infection, since this method provides no protection against infection.
- *As a contraceptive, this method is very unforgiving of improper use. If you have sex when this method tells you to abstain, you will have sex when you are *most* likely to become pregnant.

WHERE do I go to learn the fertility awareness method?

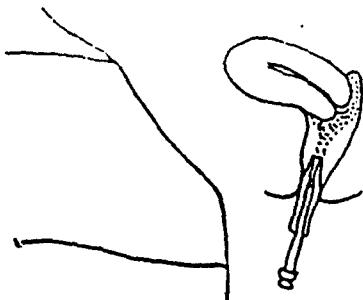
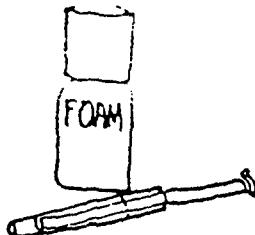
Some clinicians, and some planned Parenthood clinics can help you. An excellent book which has marvelous graphics: Taking Charge of Your Fertility: The Definitive Guide to Natural Birth Control and Pregnancy Achievement, by Toni Weschler, HarperPerennial a division of HarperCollins Publishers.

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FOAM



WHAT IS contraceptive foam? Foam is placed into the woman's vagina using an applicator and has two effects. It kills sperm which is why it is called "spermicidal". And it blocks the man's fluids from entering the cervical canal. Foam stops sperm from getting to the egg..

ADVANTAGES: *Gives the women control over use of a contraceptive.

- *Available over the counter without a visit to a doctor or nurse.
- *Can be put into the vagina 20 minutes or so before sexual intimacy but it is also effective immediately if you want to have sex immediately after putting foam into the vagina.
- *Safe, no hormones, immediately reversible.
- *The man's penis can remain inside the vagina after ejaculation
- *Fairly effective at preventing pregnancy and some infections. Foam is relatively inexpensive.

DISADVANTAGES:

- *Foam can be irritating to the vagina, and some people don't like it because it is messy.
- *It may not be protective against HIV (the virus that causes AIDS). If protection against infection is important, use condoms.
- *Foam tastes bad.
- *Practice putting foam into your vagina in advance. This will make it easier at the time of intercourse.
- *Some women do not like placing an applicator up into the vagina
- *Sometimes you can't be sure if there is enough foam in the can to protect against the next act of intercourse. So keep an extra can handy.
- *The taste of foam is unpleasant
- *The container carrying the foam is large and may be embarrassing to carry around

WHERE can I purchase foam? At drug stores and super markets.

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"The Pill"

Combined Oral Contraceptives



WHAT ARE combined birth control pills? Combined birth control pills contain two hormones, an estrogen and a progestin. They work by stopping ovulation (release of an egg) and by making the lining of the uterus thinner.

ADVANTAGES: *Pills prevent cancer of the ovary and cancer of the lining of the uterus (endometrial cancer). Pills also lower your chances of having benign breast masses.

*Pills also decrease women's menstrual cramps and pain.

*Pills reduce menstrual blood loss.

*If pills are taken perfectly, only 1 woman in 1,000 becomes pregnant in an entire year. But in actual practice the failure rate is about 20 times higher than this because of mistakes taking pills.

*Many women enjoy sex *more* when on pills because they know they won't get pregnant.

DISADVANTAGES: *You have to remember to take a pill every single day. So check your pack each morning to be sure you took yesterday's pill.

*Nausea and/or spotting are the two problems women may have the first month on pills.

*Missed periods or very light periods. Pills tend to make periods very short and scanty; you may see no fresh blood at all. Most women like this when they understand it is to be expected.

*Headaches are a side effect for some women.

*Depression is a problem for some women.

*Some women enjoy sex less when on pills.

*Use a backup contraceptive for 2 weeks if you have any question about how many pills you have missed and whether a backup is necessary.

*Serious complications such as blood clots from pills are very rare now.

*Pills can be quite expensive.

WHERE can I get pills? In much of the world, pills are available over-the-counter without a prescription. But in the United States you need a prescription. You can get a prescription for pills from your doctor, nurse practitioner, nurse midwife, health department, or Planned Parenthood.

WHOOPS!!! What if I miss pills or start a new pack late? **USE CONDOMS!** But if I am late starting my package or miss pills and then have sex without a condom, what then?

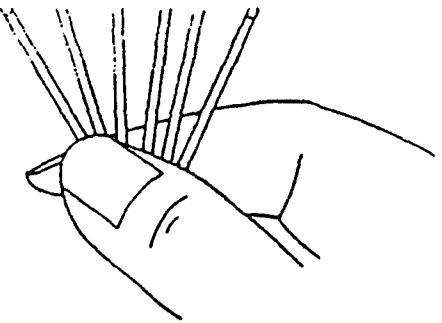
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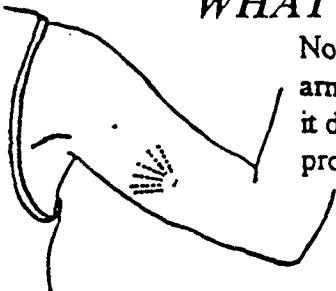
Contraceptive Implants: NORPLANT

But you have to expect some menstrual irregularity



WHAT ARE contraceptive implants (Norplant)?

Norplant IMPLANTS are 6 (six) match stick size implants inserted into the upper arm. After you are given a local anesthetic, insertion takes about 7 to 10 minutes. Usually it does not hurt. Implants give off very small amounts of a hormone much like the progesterone a woman produces during the last 2 weeks of each monthly cycle.



What are the ADVANTAGES of Norplant implants?

So effective and they last so long! If a woman is not pregnant when her implants are inserted, only 1 woman in 1,000 becomes pregnant in the first year of Norplant use. If 100 women use Norplant implants for 5 years, only one will become pregnant. That's great protection! And there is nothing to do on a daily basis or at the time of intercourse. Women using Norplant also lose less blood.

What are the DISADVANTAGES?

- *Norplant is quite likely to cause very irregular periods. If bothersome to you, contact your clinician. There are drugs that you may take to make you have a more acceptable pattern of bleeding. As time goes on your periods may become more regular.
- *You may gain weight, lose hair, develop headaches or note darkening of the skin over your implants. Implants may cause some discomfort.
- *Depression and premenstrual symptoms may improve or become worse. If these symptoms change for better or for worse, your Norplant implants may be responsible.
- *A woman may have trouble finding a physician who will remove her implants.
- *Norplant implants do not protect you from AIDS or other infections. Use a condom if you or your partner may be at risk.

WHERE DO I GO to get Norplant?

- *You can get Norplant implants from your doctor, nurse practitioner, nurse midwife, health department, or Planned Parenthood. But not all clinicians insert implants. You might want to check on this in advance. Be sure the clinician putting your implants in is experienced at removing implants and will remove them whether or not you are able to pay to have them removed.

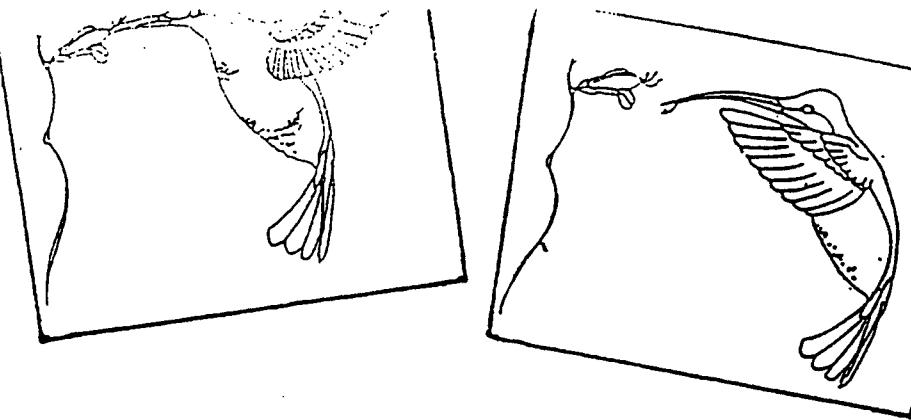
What is the ROUTINE after I have started?

- *You will probably be given a date to return about one month after insertion to check out the insertion site and to answer any questions you may have.
- *After this, return to your clinician just once a year for your regular checkup.

Choices: NORPLANT IMPLANTS; Preparation of this material was not supported by funds from a pharmaceutical company, is *not copyrighted*, and may be copied or adapted *without asking permission*.
rah: 8/2/96; 404-616-3709 or 706-782-6038;

WITHDRAWAL

(Coitus Interruptus)
Or...Pulling Out



WHAT IS withdrawal? "No deposit, no return!" When the man senses that he is about to come, he pulls his penis out of the vagina. He ejaculates (comes) outside of the vagina. This takes a lot of discipline! If the woman has not had an orgasm, the man can stimulate her in other ways after withdrawal. It works best if the couple has agreed to use this method in advance.

ADVANTAGES: *Withdrawal is always an option. Completely private.

- *No supplies and free.
- *You may be surprised at how effective it is. It is definitely better than no method at all. Actually, when used perfectly, only 4 couples in 100 become pregnant in a year of using this method (better than the diaphragm!).
- *No fluid or much less fluid is deposited in the woman's vagina. This means that there is somewhat less chance of infection spreading from a man to the woman.
- *No medical complications. No hormones.

DISADVANTAGES: *Poor protection from spread of infection.

- *The big problem is that couples want to keep thrusting when it is time for him to pull out.
- * This method gets the man thinking: "Will I withdraw in time?" And the woman is thinking "Will he withdraw in time?" This concern may decrease their enjoyment of intercourse.
- * In typical couples the failure rate is high, close to 20%

WHERE can I get this method? All you need to do is to pull out in time.

OOPs we had sex! What can I do if we change plans and we have intercourse and he comes inside of me? Sperm swim very fast. In minutes after ejaculation into the vagina, sperm are up through the uterus into the fallopian tubes, where they will meet up with the egg, if an egg is there. But it still may help if you wash the sperm out of the vagina quickly (or douche): if you have a spermicide available, put an applicatorful of a spermicide into the vagina right away. Even if you do this you are probably too late!

WHAT IF I HAVE SEX AND DON'T USE BIRTH CONTROL?

Did you know that... for 72 Hours... after sex, you can take emergency pills to avoid becoming pregnant? AND for 5 Days... after sex, you can have an IUD put in, so you won't become pregnant. Not all doctors know about this. If you need to know more or would like the phone numbers of doctors or clinics near you that have emergency birth control,

Call: (800)- 584-9911....

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Appendix D

Pregnancy Fitness Program

MAJ Mary Jo Laurin

United States Army Center for Health

Promotion and Preventive Medicine

(USACHPPM)

13 Nov 1998

INFORMATION PAPER

SUBJECT: Pregnancy Fitness Programs

1. Purpose. To explain the current status of the Pregnancy Fitness Program.
2. Facts.
 - a. Currently, there is no established Army program for pregnancy physical training.
 - b. There exist, however, several pregnancy programs established by the Medical Treatment Facilities (MTFs) of USAMEDCOM. The USACHPPM's goal is to develop a program to implement Army-wide.
 - c. The information gathered from these facilities' programs will be used to develop an exportable package of instructions on how to implement a pregnancy fitness program for the installation. A contractor will design a train-the-trainer package for certification of pregnancy fitness exercise leaders.
 - d. Once the pregnancy fitness program is complete, it will be staffed for approval and then disseminated.
3. POC at USACHPPM for this program is the author of this paper.
4. Current POCs and locations of several pregnancy fitness programs:
 - a. CPT Chatman-Brown, Fort Sill, DSN 866-2913
 - b. MAJ Warrington, Fort Drum, DSN 341-6404
 - c. CPT Kevin Werthmann, Fort Carson, DSN 883-3923
 - d. CPT Leazenby/Crystal McGee, Fort Benning, DSN 835-4041/8038
 - e. LTC Page, Fort Polk, DSN 863-3900
 - f. LTC June Mikkila/Susan Watts, Fort Hood, DSN 737-0281/6789
 - g. CPT Anne Sigouin, Fort Campbell, DSN 635-8151

MAJ Mary Jo Laurin
DSN 584-7008

Pregnancy Fitness Train-The-Trainer Program for the US Army

Scope of Work

Purpose: The contractor will provide the US Army with a Pregnancy Fitness Program as described below.

Description:

1. There will be three levels of personnel involved in the Pregnancy Fitness Program

a. Experts – These people will take the program, and without any other training, be able to instruct it to others who do not have training in pregnancy fitness. These "Experts" must have a background in any of the following: midwifery, OB nursing, physical therapy, exercise physiology or a nursing with a strong background in fitness. The "Experts" will either be located at each installation or in a single location, such as the US Army Physical Fitness School. The "Experts" will be available to the Instructor Trainers (IT) for any questions or help the ITs may need to operate the program. The "Experts" will be allowed to reach the contractor for any questions they have regarding the program. This service provided by the contractors will be available for three years after implementation of the program. If the Fitness School operates the program, then the "Experts" for the Fitness School will be trained by the contractor for the normal course price, not to be included in this contract.

b. Instructor Trainers – These people are taught by the "Experts." Instructor Trainers (ITs) will be taught information on pregnancy fitness so that they can train Exercise Leaders to actually lead the pregnant soldiers in pregnancy fitness. Personnel to be considered for instructor training should have a minimal fitness and/or medical background. The intent would be to have at least one Instructor Trainer per installation. If the "Experts" are located at the installation, the Instructor Trainer would be trained at the installation and would then be responsible for the pregnancy fitness program. If the "Experts" are located at the Fitness School, then the personnel will come to the Fitness School for the training and return to their respective installations to operate the program. "Experts" located at the installations would not necessarily operate the pregnancy fitness program since the "Experts" in most cases already have a full time job.

c. Exercise Leaders – These people receive training from the ITs on how to lead pregnant soldiers in a fitness program. There are no qualifications required for this person, although it is recommended to use other soldiers, and preferably Master Fitness Trainers (MFTs) for Exercise Leaders.

2. It is recommended that the "Experts" be located at the Fitness School. This is important to keep the expertise centrally located and to ensure that the same instruction is disseminated Army wide. The "Experts" at the Fitness School would be initially trained by the contractor, which would allow direct hands on training and learning from the contractor. (Cost of this training is not included in this contract, but will be funded at a later date). After this initial training, the contractor would be available for consultation for a period of three years. (The consultation would be part of this contract). Due to the expense, direct training by the contractor would not be possible if the "Experts" were located at each installation. Since at this time, we do not know whether the "Experts" will be at the Fitness School or each installation, the package created by the contractor will be designed so that the personnel with the backgrounds mentioned in paragraph 1a, could teach the IT course effectively without direct training by the contractor. The only assistance that would be allowed in this case would be from the contractor by phone.

3. The information provided in the pregnancy fitness program needs to be geared to the US Army pregnant soldier. The following should be considered in the development of the program:

- a. Physical fitness or training occurs in most units three times a week in the morning.
- b. The time allowed for exercise in most units, including warm-up and cool-down, is one hour.

c. The average pregnant soldier is generally in better physical condition than the average pregnant civilian is.

d. Physical training or fitness is generally mandatory for the pregnant soldiers.

e. The pregnancy fitness program must include an upper body, abdominal, and cardiovascular workout as a minimum.

4. The pregnancy fitness program must include a post partum program that a soldier will begin at home and then transition to group participation, 6 weeks post-maternal leave.

a. Soldiers are typically NOT motivated to do exercise at home. The program should include motivating material to help encourage the soldier to begin exercise at home.

b. Goal of the post partum program is for the soldier to reach the height/weight and body fat standard six months post partum.

c. The second goal of the post partum program is for the soldier to pass a fitness test that consists of push-ups, sit-ups, and a 2 mile run, six months post partum.

5. Education of pregnancy, not related to fitness, will be the responsibility of the Army Medical Treatment Facilities, and NOT the responsibility of the contractor's program. United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) will provide a list of recommended classes to the MTF. USACHPPM will also collect, store, and disseminate by request any classes an MTF is willing to provide.

6. The contractor will provide at minimum five copies of all teaching materials developed and required for training Experts, Instructor Trainers, and Exercise Leaders.

7. POC for this scope of work is MAJ Mary Jo Laurin, Physical Therapy Staff Officer, USACHPPM, at (410) 436-7008.

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REMARKS

Attached "Strategy Research Project" Paper
 SUPERSEDES previous SRP sent to DTIC 8/11/99.

Any questions please contact Melody Baker,
 at (717)245-4317.

THANK YOU.

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